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CULTURAL PLURALISM AND ETHICAL-DECISION MAKING: THE ANNANG OF SOUTHEASTERN NIGERIA

©

BY:

CORAL LYANNA PAUL (NEE GUNDERSON)

A THESIS SUBMITTED TO THE FACULTY OF
GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF
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MASTER OF NURSING

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"AS NATIVES, PROCESS DETERMINES TIME...

IN THE WHITE WORLD, TIME DETERMINES PROCESS"

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PAMELA BRINK, PHD., RN. (SUPERVISOR)

JOHN DOSSETOR, MD.

JEAN INNES, MSC, RN.

DATE: September 14th, 1992

Dedication

This thesis is dedicated to the **Annang** of Southeastern Nigeria whose value of family has given me a greater appreciation of my own; past, present, and future; nuclear and extended; genetic and selected.

In particular I acknowledge the Late Mr. **Christopher Akpan Jacob Ebong** (1932-1958) friend and mentor, who during the period of this research (and well after through correspondence), transcended the boundaries of culture, kinship, gender, and age encouraging the author to "tell the world about family in **Annang** tradition, as completely as you can, good and bad, right and wrong, so that you may come to know our ways and so that the **Annang** may value what they too offer the world."

ABSTRACT

A major issue affecting health interactions between diverse cultural groups is the limited understanding of the values, facts, and contexts in which ethical dilemmas arise. Combined with structural, linguistic, educational, socio-economic and legal barriers, and the lack of representation of minority groups in decision-making bodies may lead health care professionals to arrive at ethical decisions which reflect dominant values rather than a true discharge of moral obligation. At present, there is a lack of research, and specifically nursing research, related to the application of ethics cross-culturally. Through a beginning exploration of the means by which variant cultural groups reach health care decisions, insight may be gained as to whether the groups themselves acknowledge an ethical foundation to decisions, utilize similar or diverse ethical principles, and/or other decision-making models not presently reported in health sciences literature. In 1989, a qualitative study was undertaken which examined

the ethical decision-making process of the **Annang** of southeastern Nigeria. A descriptive/ ethnographic design using case studies, semi-structured interviews, demographic data collection and participant observation was employed. Findings juxtaposed the differences between "ideal" and "real" decision-making by examining ways in which the **Annang**: 1) believe health resources "ought" to be utilized; 2) described themselves to use health resources; and 3) were observed to meet health needs in their cultural milieu. Unique to the **Annang** is that ethical principles which commonly guide western ethical decision-making were superceded in all cases by an **"ethic of family."** The impact that such an ethic may have for the area of bio-ethics and health care will require further research through etic and emic as well as qualitative and quantitative means. This must be done in order that the culture bound and/or cross-cultural implications of such an ethic for bio-ethics and health care in general may be evaluated.

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CHAPTER I

Cultural Pluralism and Ethical Decision-Making

Numerous studies in the health sciences suggest health care systems and the individuals who work within them may reflect dominant cultural values, be primarily accessible to middle and upper classes, and be supported by political, legal, socio-economic and educational factors, which contribute to the reproduction of dominant cultural values (Martin and Henry, 1989; Friere, 1987; Pesznecker, 1984; Mason, 1982). In addition, the social, cultural, and institutional barriers which may be reflected within health care systems, at times go unchallenged provided the needs of the dominant culture are adequately met. Individuals representing cultural minority groups and experiencing the vulnerability of a health crisis, however, seem to be required to suppress and/or alter their values and beliefs in order to meet health needs and find meaning in dominant cultural environs (Meleis and Jonsen, 1983; Milio, 1967).

Knowingly or unknowingly, health care professionals represent and/or exercise the authority conferred on them by the powers of

western medicine, education, science and technology. As Weidman states however: "unicultural or unidirectional health care in which the practitioner imposes his/her own concepts upon the patient, exhibits an unintended but very real intolerance and contempt for the patient's cognitive system" (1982, p.508). One health care area in which such issues are becoming more evident is where ethical dilemmas arise, requiring the utilization of moral principles upon which decisions are formulated.

Increasingly ethical dilemmas occur as a result of variant interpretations of factual information, the correct scientific, metaphysical and/or religious description of the situation (Dossetor, 1992; Banning, 1992; Giger and Davidhizar, 1991; Engelhardt, 1992; Davis, 1989; Last, 1987; Callahan, 1987; Beauchamp and Childress, 1983; Meleis & Jonsen, 1983; Capra, 1983; Gilligan, 1982). This situation can result in three possible outcomes. First, a potential for individuals with variant beliefs to lose the opportunity to be an equal member in the ethical decision-making process. Second, health care

professionals may be placed in ethical decision-making positions where they have neither the academic, experiential nor clinical expertise upon which to base ethical judgements. Or third, a situation in which variations in patient and health care professionals values and beliefs bring the ethical decision-making process to a standstill.

A major issue affecting health interactions between diverse cultural groups is the limited understanding of the values, facts and contexts in which ethical dilemmas arise (Banning, 1992; Steele and Harmon, 1983). Most recently these factors have combined to create difficulties in the areas of: genetic screening, organ transplantation, pediatrics, and emergent care. Perhaps the most profound effect of relying solely on western philosophical traditions to answer ethical decisions is the tendency to be paternalistic to individuals not steeped in such traditions. Combined with structural, linguistic, educational, socio-economic and legal barriers, the presence of partial facts and lack of representation of minorities in decision-making

bodies may lead health care professionals to arrive at ethical decisions reflecting dominant values rather than a true discharge of moral obligation (Meleis & Jonsen, 1983).

Presently, there is a lack of research, and specifically nursing research, related to the application of ethics cross-culturally. Such research could assist practitioners in their attempts to validate and/or expand upon existing moral principles which form the basis of ethical decision-making models in the health care field today. Through a beginning exploration of the means by which variant cultural groups reach health care decisions, insight may be gained as to whether the groups themselves acknowledge an ethical foundation to some decisions and/or utilize other decision-making models not previously identified in the literature. Furthermore, the documentation of the beliefs and values underlying the health care decision-making processes of culturally variant groups may illuminate potential areas of conflict between health care professionals and the clients they serve.

African Culture and Ethical Decision-Making

On a cross-cultural level the meanings assigned to health issues are known to be

influenced by history, environment, economics, education, beliefs, values, rituals, philosophy, religious attitudes and socio-political traditions (Umoren, 1990; Veatch, 1989; Beauchamp and Childress, 1983; Oji, 1982; Apostel; 1981; Callahan, 1988; Carper; 1986; Brink, 1984; Carnoy, 1984; Udom, 1985; Freire, 1987; Kilner, 1983; McGuire, 1987; Kluckhohn and Strodtbeck, 1961; Kleinman, Eisenberg and Good, 1978; Maquet, 1972; Messenger, 1970; Milio, 1967; Minami, 1985; Johnstone, 1988; Steele and Harmon, 1983; Storch, 1982; Wright, 1987). Research as to the way in which such factors influence the ethical decision-making processes of variant cultural groups however, is lacking (Veatch, 1989; Wright, 1987; Carper, 1986; Minami, 1985; Beauchamp & Childress, 1983; Storch, 1982; Jonsen and Meleis, 1983).

Although a number of authors have studied the moral foundation of decision-making for: Africans (Bodunrin, 1985; Mason, 1985; Apostel, 1981; Maquet, 1972; Horton, no date; Carothers, 1948), and Nigerians (Obarisiagbon, 1988; Etuk, 1987; Amadi, 1982; Peel, 1978; Maclean, 1971; Uchendu, 1965; Talbot, 1923), few, if any, have examined in

depth, the rationale underlying the decisions made. Two noted exceptions to this statement are the works completed by Kilner (1984, 1983, 1981) and Turnbull (1972).

Kilner (1984, 1983, 1981) examined the Akamba of Kenya, and how decisions related to the allocation of scarce medical resources in their community were made. Kilner believed "approaches to the microallocation of scarce lifesaving medical resources would be greatly enhanced by discussing the problem with people operating out of a different cultural framework" (1984, p.18). Through the use of story telling, Kilner discussed "ethical" issues with those persons he believed to be most knowledgeable about ethics in their community. The sample included "healers" of two types: traditional healers and professional health workers. Kilner concluded that the Akamba do not necessarily offer a case for moral relativity in the area of scare medical resource allocation. This meant the Akamba did not demonstrate moral codes which varied from person, place and time in their community. Rather, it is suggested that the variance in ethical decision-making demonstrated

by the Akamba reflects differences in "knowledge or beliefs (about what benefits society most...the nature of eternal life, or God's role in healing) rather than of moral judgement" (1984, p.19).

Turnbull, in his noted 1972 book "The Mountain People" documented the gradual dehumanization of the IK of Uganda, who in a period of three generations moved from a self-sufficient tribe of hunter/gatherers to a people destitute and near extinction. Through field observations, Turnbull witnessed the extreme sociological transformation, brought about by environmental, social, cultural, economic, and communication transfer. These factors together, altered the precarious ecological balance this society had maintained for centuries. A shift in the "carrying capacity" of the land moved the Ik from a communal to individual focus. Although the stress brought on by rapid change was first noted in disfunctional communal activities, soon basic units of the community also suffered; that being the family. Mothers were turned against children, husband against wife, and son against father. Turnbull offers great insight on the impact

"context" may have for shaping community and individual ideas about "right" and "wrong," "good" and "evil," "what "ought" or "ought not" to be.

The Annang of Nigeria

Nigerian, and **Annang** scholars, have explored a multiplicity of factors which contribute to the health and related health care decision-making processes of their people. Descriptive works have examined: forms of religion (Umoren, 1990; Udo, 1983a; Noah, no date), education (Akande, 1987; Olukoya, 1986; Oni, 1985), socio-economic and historical considerations (Udomesiet, 1983; Udo, 1983a, 1983b; Afigbo, 1977, 1971; Sanda, 1976; Uchendu, 1965; Ekandem, 1957; Johnson, 1932), totems and social taboos (Udom, 1985; Amadi, 1982). A number of authors have also detailed: traditional healing practices (Oyeneye, 1985; Atuado, 1985), the utilization of western medical traditions (Igbinosun, 1990; Aminu, 1985), African psychotherapy (Aeanbor, 1982), and health concerns for Nigerian populations (Oyeneye, 1985; Ransome-Kuti, 1986; Aminu, 1985; Oyebula, 1980; Ojo, 1974 & 1965; Ogbeide, 1968, 1967). To a somewhat lesser degree, writings appear on women's issues (Mba,

1982; Jeffreys, 1950), the family (Amadi, 1982) patient rights (Obarisiagbon, 1988), and culture (Achebe, 1964, 1960, & 1958).

A number of **Annang** sources describe the moral foundations of **Annang** society, as well as general principles which guide activities of daily life (Udo, 1983a; Amadi, 1982; Essien, 1980; Messenger, 1970; 1959a, 1959b, 1959c, 1957; Forde and Jones, 1950; Talbot, 1915a; 1915b; Talbot, 1914a; 1914b). These works offer insight into the unique ecological balance which has evolved for the **Annang**; a balance believed to influence the rationale underlying their health care decision-making processes. These records do not however, detail ethical decision-making processes utilized by this tribal group.

Proverbs have long been used to communicate beliefs, values, morals and philosophies to successive **Annang** generations (Essien, 1980; Amadi, 1982; Kofoworola, 1988; Messenger, 1959a). Since many **Annang** cannot read or write, proverbs are still considered to be one of the principle forms of community education and cultural reproduction. As Essien states:

> The kind of wisdom contained in the philosophical attitude of proverbs does seem to aid a man to cope with whatever position he has in the kaleidoscope of life...On the practical daily level...proverb ethics ease the tension of those who are associated with it...In a dynamic, flexible sort of way, proverbs, according to the manner in which they are put to use, allow for expressions of conflicting attitudes...The oral society being intolerant [of change] has to be homogenous in order to provide set replies [to unpleasant matters]...by a unique technique they allow a limited tolerance in such a society...the use of proverbs seems to mellow and abolish the class of contradicting opinions that appear to be common in oral societies (Essien, 1989, p.124).

Proverbs amongst the Annang are used to detail issues and the context in which they occur. Proverbs examine relationships and the impact problems, decision-making and solutions have for the family/ community/tribe involved. Their very form is relational, humble, and modest in tone. They allow one to examine humaneness and are useful in a community that has pragmatic and communalistic approaches to solving human problems. The role that proverbs have for ethical decision-making amongst the **Annang**, as it relates to health care however, has not been examined.

Foreign scholars have also contributed to an understanding of the **Annang** and the means by which they make health care decisions within their socio-cultural milieu. Messenger's work (1970, 1959a, 1959b, 1959c,

1957) has detailed the various effects of the acculturative process for the **Annang**. Specifically, he has examined: Christianity, religion, proverbs, education and cultural contact on the **Annang**, who evaded foreign domination and the effects of acculturation until the end of World War I. Messenger's findings suggest there has been a gradual erosion of traditional culture for this tribal group; the outcome of an uncensored application of western education, and Christianity. The result is a period of "anomie" for younger **Annang** generations who seek to explain the world and their place in it without a substantial understanding of either traditional and/or western values, beliefs, morals and/or cultural norms.

Existing documentation also provides evidence, albeit "etic," of the allocation of scarce family resources by the **Annang**. Historically, twins and their mothers symbolized "bad omens" for families requiring isolation, segregation and in the extreme - death. It was believed two infants born to a mother at the same time would unnecessarily tax her resources thereby placing the family (and the continuation of the lineage) in jeopardy (Simmons, 1960; Talbot, 1923;

Talbot, 1915a, 1915b, 1914a and 1914b; Forde and Jones, 1950). An **Annang** proverb imparts the wisdom about the unnatural act of bearing twins proclaiming: **"Annang Ise Imana Iba** -Cows can't give birth to twin calves" (Regina Udomesiet, 1989). With the advent of colonial rule and Christianity, twins were saved through the establishment of "twin towns" where children were taken and raised to adulthood (Talbot, 1915a). Such children however, were seldom welcomed back into the **Annang** family or the community. Today, although twins and their mothers are no longer put to death, they are still considered by the majority of villagers to carry "bad" omens (Brink, 1980). This is evidenced in the practice of today's native healers or **"Idiong** men," who after fathering twins, banish the mother and children to separate compounds, never to lay eyes upon them again.

Although numerous scholars including Umoren, Messenger, Essien, Udom, and Udoh, have contributed to a growing understanding of the **Annang**, only one of note, Brink, has studied the area of health care and health care decision-

making for the **Annang**. For this reason, these works were explored in greater detail for the study.

Research by Brink, on the "Fattening Room" has offered additional understanding as to the allocation of scarce resources for the **Annang** (1991, 1989a, 1989b, 1989c). In an environment where child mortality rates are 40 per cent and life expectancy 48.5 years, enormous value has been placed upon fertile, and more importantly fecund, women in the community (Brink, 1991). Traditionally, pre-pubescent girls were readied for marriage by entrance into a secluded "fattening room" for periods of up to seven years, at a cost borne by the family. During this period of "**mbobo**," girls were cared for by older women, went through female circumcision, gained access to "women's knowledge," and achieved greater social status, and a higher bride price (Brink, 1991, 1989a and 1989b; Talbot, 1915a and 1923; Jeffreys, 1958). Girls who did not become **mbobo** were relegated to a lower social status, denied entrance into some women's societies, and brought great shame to the extended family. Less well

documented is the belief that girls unable to be fattened were unhealthy and unfit for marriage and motherhood; not worthy of the investment of scarce family resources (Jeffreys, 1958).

The importance of values in ethical decision-making has been underscored by numerous authors. Most recently, nurse ethicist Sarah Fry, was quoted as saying "the health care of any patient raises many questions of ethics. The consideration of values in health care falls within the realm of ethics because value orientations typically provide the foundations for the judgements we make within the health care system" (Reid, 1992, p.25).

In 1984 Brink examined the value orientations of 28 **Afaha Obong Annang** (15 men and 13 women), using Kluckhohn and Strodtbeck's 1961 Value Orientation Schedule. Orientations were measured in four areas: activity, relation, time and man-nature. The Schedule provided a systematic ordering of cultural value orientations to a set of common human problems, previously tested with other cultural groups. Brink's value orientation research provided a value profile,

Table 1

VALUE ORIENTATIONS OF THE ANNANG

This table has been removed from this document due to copyright restrictions. The value orientation profile of the Annang of Nigeria is found in the following reference:

Brink, P.J. (1984). Value orientations as an assessment tool in cultural diversity. Nursing Research, 33 (4), p.202.

(albeit static), of the **Afaha Obong Annang**. The profile (see Table 1) suggests the **Annang** emphasize collateral relationships, (in the form of the extended family), and this relationship is preferred to individual and lineal relationships. The **Annang** also value the present over the future, placing little measurable emphasis on the past. In the area of activity, it was ascertained the **Annang** preferred being to doing, suggesting the **Annang** are more concerned about "who" the person is at the present moment, rather than "what" they can accomplish in the future. In the area of man-nature, the **Annang** demonstrated no preference when considering whether they believe they are subjugated to nature, in harmony with nature, or have mastery over nature. Brink believes this may be the result of the **Annang** having greater cultural contact with groups outside their geographic area, made possible through the tools of technology, communication and travel. Although the research completed by Brink offers a value profile of the **Annang**, to date, there has been no link between the profile and ethical decision-making processes exhibited by this cultural group.

A 1976 decision-making model advanced by Brink for the **Annang** health care consumer placed "the potential patient within his cultural and social milieu and looked at the effects of that milieu upon his subsequent decisions" (p.3.). The **Annang** were found to utilize a decision-making process for health care services whereby: an individual was deemed to be ill; assistance with the health matter was believed to be necessary; a healer was chosen; an agreement was made for the healer's services; and a decision about the patient's health wellness continued and/or discontinued services (see Appendix B). Brink's findings suggest: 1) much of the decision-making process by **Annang** villagers occurs prior to accessing the traditional, western and emerging health care systems, and 2) the family retains their right to make decisions pertaining to health care delivery following entry into the health various care sectors. The formulation of the model however, was abstracted from the setting within which it occurred and may have evolved from the values, beliefs and attitudes of the researcher and not necessarily those of the **Annang**. In

addition, the rationale underlying the decisions reached by the **Annang** have not been explored by another researcher. As Brink suggests, certain limitations are inherent in the model, therefore requiring "further exploration across cultural boundaries...and among the **Annang** themselves" (1976, p.13).

To achieve a solution to a problem, one utilizes a decision-making process where there exists: 1) an area of uncertainty; 2) a set of alternatives requiring evaluation; 3) criteria by which the alternatives are evaluated; and 4) an eventual choice between alternatives (Gladwin, 1989; Gage 1983). Decision-making has also been termed a means by which to resolve controversies. To reach a decision in an ethical dilemma, where moral reasoning can exist both for and against a particular course of action, four additional factors must be considered. One must: 1) be committed to do good; 2) have a knowledge of relevant facts; 3) have clarity in dealing with the facts; and 4) utilize some ethical principles which guide the process (Reid, 1992; Beauchamp & Childress, 1983; Storch, 1982). With the exception

of Brink's (1976) research on health care decision-making, little published information examines the way in which the **Annang** arrive at decisions impacting on individual and family health status (Brink, 1976). No information is available which examines the way in which ethical decision-making by the **Annang** occurs.

Summary of the Literature

The literature suggests a variety of factors influence health care decisions made by **Annang** family groups. Such decisions are made at a cost they can afford, in terms of both economic and familial resources. Despite the available information, it remains unclear however, how health care decisions are made by the **Annang**, the context in which they occur, and whether the decisions constitute ethical choices. Questions arising out of the literature include issues such as: do the **Annang** utilize the same and/or different moral principles as western cultures in the allocation of family resources? If the **Annang** value patrilineage more than personal autonomy, what are the implications for health care decision-making? Are women considered to be as

autonomous as men and if so, are they recognized as autonomous individuals in the decision-making process? If there is only enough of a life-saving treatment for one person and two individuals require it, how is the treatment distributed? Is the decision the same for: women and men; old and young; married and unmarried? To what extent does the present Nigerian economic crisis impact on the decision-making processes of **Annang** families? Furthermore, to what extent do the concepts of social value, random selection and religious justification impact on the decision-making processes of the **Annang**?

Computer and manual searches of the health and social science literature published prior to 1992, isolated only one study where health care decision-making processes were examined for the **Annang** of Nigeria. No studies were identified which examined ethical decision-making in relation to health care resources for the **Annang**. Although a number of ethicists have written descriptive accounts on the existence of varying perspectives when examining ethical decision-making cross-culturally, most analyze the process from western

philosophic traditions, defining "etically" what constitutes an ethical dilemma and not "emically" by the cultural group themselves.

Despite the fact that each article surveyed noted the cultural specificity for which beliefs, values, attitudes and practices evolve, few systematic attempts have been made to examine the impact these factors have for health care decision-making and the field of ethics. For this reason the present study served to: 1) describe and verify health care decision-making processes for a culturally variant group, the **Annang**, and 2) describe ethical approaches (if any), undertaken by the **Annang** in health care decision-making.

Statement of Purpose

The purpose of the study was to explore and describe the ethical decision-making processes of one culturally variant group, the rural **Annang** of southeastern Nigeria, between June 28th, 1989 and August 23rd, 1989.

Assumptions of the Study

The following assumptions were important in understanding the research study:

1. The informants, as members of the **Annang** culture, are considered experts of their culture.

2. The concepts underlying decision-making processes by **Annang** villagers do not necessarily reflect decision-making processes used by their ancestors.

3. Values, beliefs and attitudes underlying decision-making processes of **Annang** villagers influence the manner in which family health needs are met.

4. **Annang** villagers may or may not have ethical decision-making models different from those utilized by health care professionals.

5. Ethical decision-making is contextual, influenced to a large extent by history, politics and economics.

6. Ethical decision-making frameworks may be culture bound.

CHAPTER II

Population

The target population for the study was all **Annang** villagers living in rural areas of southeastern Nigeria. The **Annang** live in an area of Nigeria where tropical rain-forests have been decimated and replaced with palm groves, farm plots, and large numbers of Christian and juju shrines. **Annang** villagers live a basic hand hoe existence and only recently have experienced the acculturative process that accompanied British Colonial rule (Udo, 1983a, 1983b; Essien, 1980; Brink, 1982). **Annang** population estimates approximated 2,124,800 prior to the imposition of Nigerian censorship laws shortly after Babangida's rise to power following a peaceful coup in 1985 (Udo, 1983a).

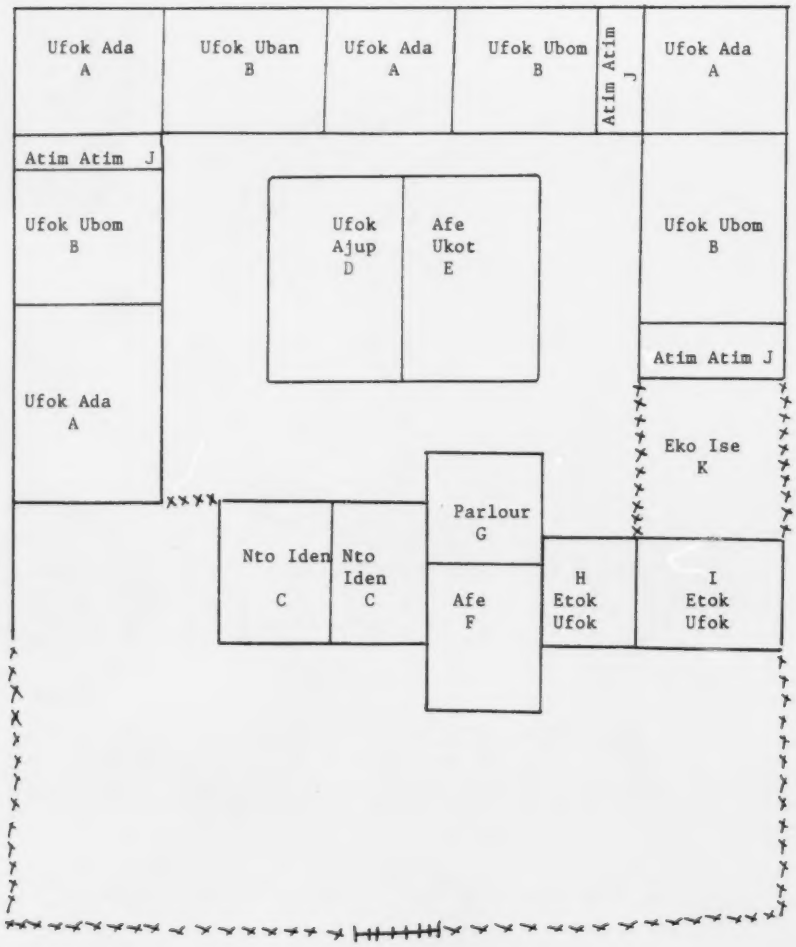
The **Annang** are a semi-Bantu speaking people, considered to be the last tribal group in southeastern Nigeria to have come in contact with Europeans (Forde and Jones, 1950). **Ibibio** is the language for **Akwa Ibom** State, as it is the "principle medium of education, commerce and Christian religion" (Essien, 1980, p.8).

The **Annang** live mainly in extended family compounds on land inherited by the family via patrilineage (Brink, 1976). The family unit is called the "**otung**" and all members of the family tracing their geneology to a common male ancestor form what is known as an "**ekpuk.**" The smallest extended family unit is known as the "**idip**" which lives together in a compound or "**atung.**" When planned and built as in Diagram 1, the compound is referred to as an "**ikure,**" meaning fenced or walled abode wherein the senior male is dominant and all others subordinate (Akpaidiok, 1989).

The word **Annang** means :"conqueror, warrior, fighter, soldier and collectively, a battalion of invaders" (Akpaidiok, 1989, p.5). The head of the **ekpuk,** the eldest living male of the lineage, assumes total responsibility for all members of the extended family grouping. The acceptance of this responsibility is called the law of "**ajejen,**" including: all decisions related to the welfare of the extended family, the over-seeing of all births and deaths, family education, clothing, shelter, adjudication of marriage agreements, setting and/or paying bride price, decisions on family participation in traditional societies, religious

Diagram 1

Ikure: Annang Family Compound



IKURE - ANNANG FAMILY COMPOUND

A Bedroom
B Kitchen
C Son's Room
D Storage
E Family Lounge
F Reception
G Parlour
H Bedroom
I Bedroom
J Storage
K Barn
X Fence
Gate

Akpaidiok, S. (1989). Annang Heritage. Unpublished Paper. Abak, Nigeria.

affiliation, administration and representation of all family matters, provision of food and water as necessary, mediation of family disputes, assessment and allocation of scarce family resources and a host of other related roles and tasks. With many similar family groupings in each village, the **Annang** have come to "rely on the cooperation of their kin and neighbors; very rarely on jobs or salaries" (Essien, 1983, p.8).

The preferred marriage type amongst the **Annang** is polygamy, despite the proclaimed Christianization of villagers. Married women, move to the husband's compound and retain ties with their father's village when and wherever possible. During the wife's life span, assistance can be sought from her father's village at any time, her children become grandchildren to all members of her father's village and are given special status and privilege (Brink, 1984). The maintenance of extended family ties with the wife's family is called the law of "**ukot**" and requires allegiance to, and support of all, family members. An additional law of "**iman**" or race, requires obligations far less encompassing in scope than

the laws of Ajenjen or Iman, through support of fellow tribesmen and traditional **Annang** cultural practices. This supposedly ensures cultural survival of the community.

As the **Annang** family unit expands, so too do the responsibilities of the family head **"akpan"** (or senior son). The man in this situation, is the accredited bread winner and therefore the undisputed decision maker in the home. The husband gives orders and assigns functions to the rest of the family including the wife/wives and children from whom he expects, and receives, total submission.

The **Annang** have solicited research among their people, for three major reasons. First, historical information sources available to the **Annang** in the education system reflect the views and beliefs of **Ibo** and **Ibibio** cultures in surrounding districts but are not representative of the **Annang**. Second, most documents pertaining to the **Annang** detail cultural traditions, beliefs and values which may or may not mirror the views of the colonials and/or a compradore elite who document them. Third, **Annang** elders hope that by

providing **Annang** information to younger generations, new **Annang** scholars will be groomed and go on to write stories of, and for, **Annang** people.

Health Care Resource Available to the Annang

In a 1976 decision-making model for the **Annang**, Brink documented three "separate and distinct" systems of health care available to extended family units: 1) the traditional system; 2) the western system; and 3) the emerging system. This tripartite health system was still in existence during the present study, with minor modifications to its' form and constituents. Each system is still believed to be accessed following a voluntary choice by individuals, but only after the extended family has made a number of decisions in relation to the member considered to be ill.

The **Traditional Healing System,** is comprised of native healers and/or fortune tellers (commonly called **"Idiong** men" native midwives, and "people who know about medicines" (including individuals having knowledge of, and methods for, procuring traditional remedies used to treat a variety of **Annang** disease and illness conditions). Medicines

and cures offered by individuals within this system address: fevers, bleeding, pain, diarrhea, vomiting, infertility, hernias, cuts, mental illness, cardiac conditions, fractures, childbirth, anorexia, malaria, wounds resulting from accidents, constipation, headaches, insect and reptilian bites, tuberculosis, unwanted pregnancies, senility, pre-menstrual and menstrual symptoms and a host of other concerns too numerous to list. The Traditional health system is readily accessible to most villagers, being found within one's own, or nearby village(s). The system combines alternative modes of healing with religious values and beliefs common among the villagers and supported by local clan heads, respected elders and some primary health care professionals. Fees for service take the form of gifts and/or promises for future payment. Seldom are services observed to be withheld from those in need for reasons of economic insufficiency.

The **Western Health System** is made up of primary, secondary and tertiary institutions, administered by the federal government, private practitioners and/or non-governmental organizations. A variety of health

care professionals (including physicians, nurses, midwives, etc) are trained and educated in conjunction with governmentally run institutions, and granted degrees and/or licenses to practice in the state in which they are educated. Services offered by the western health care system are varied, and encompass acute care services, and health promotion strategies such as well prenatal care, baby clinics, and immunization programs. Most often they are designed to meet acute care needs of the citizenry.

During the present study, few western health care services were offered free of charge, and were often withheld until a deposit on the services was made. This situation varied in emergencies in which case patient's were stabilized and further treatment postponed until methods of payment could be secured. As a result of national and local economic constraints, if the patient was considered in any way to be a financial risk for the hospital or health care facility, verbal promises for payment were obtained from extended family members or village clan heads. In a number of villages, although child immunizations were free, individual records

had to be purchased prior to immunization for 5 **naira**. Each child required their own record, and some villagers found this meagre cost prohibitive for services. The result was that community based health care services were greatly underutilized by the population they were designed to serve.

Despite health care professional assertions to the contrary, western health services were not readily accessible to villagers, who were expected to travel significant distances in various states of health, to have needs met. Health professionals were not observed visiting the homes of the villagers, or seen to be accessing them at any of the various communal meeting places. Similarly, with the impact religious groups had on villagers, few, if any, attempts were made to contact actual or potential clients through, or in conjunction with, these groups. No known attempts were being made to access individuals in the various formal or informal religious training areas in order to facilitate future health care innovations and improvements (personal communication, Mrs. Ekpo, Primary Health Care Nursing Supervisor, Abak

Area, 1989). As a result, western health services requiring patients to come directly to the facilities were believed to be poorly utilized by the researcher and by Nigerian health care professionals interviewed and observed during this study. In some instances, staff in the primary health care units actually exceeded the number of clients three or four times. This was not true however of tertiary facilities, where occupancy rates were seldom below maximum capacity.

An additional reason for the poor utilization of western health care services may be the perception of fear that villagers stated they had in relation to such services. Numerous informants revealed that many **Annang** believe the "spirits of the dead gather around the hospital and haunt those who stay on the premises" (Udoh, 1989). For this reason, it was stated that family members seldom stay with loved ones during the hours of darkness. Few relatives during this study were witnessed to stay with family members in hospital during the evening hours. A second perception of **Annang** villagers, is that hospital

staff can be rough and hold positions of hospital seniority over the heads of the villagers who come in for acute care needs. During the study, some health workers were witnessed by the researcher and **Annang** interpreters to be verbally and physically rough with the patients they cared for. In one instance, a mother had brought an infant to the community health centre where neonatal tetanus was diagnosed in the child. Interpreters stated the nurses spoke harshly to the mother and criticized her for lack of attention to her infant, in front of seven other women and their children. The nurses justified their actions as an opportunity to reinforce in public, the need for adequate childhood and maternal immunizations. The mother in this situation, was left crying, holding the rigid, spasming child, (who was 7 days old), aware that death was imminent, no cure available, and that health staff believed she alone would be responsible for the death.

Of great concern in relation to the medications used in the western health care systems, is the present theft of pharmaceutical

shipments. Physicians interviewed noted hospital orders were increasingly being replaced with out-dated or "fake" medications. Stolen shipments later appear on the black-market, in chemists shops, or in village markets where they sometimes are sold according to color, size and shape. There are a number of repercussions for such practices which health workers believe arise largely out of economics and the limited ability to adequately protect transported medical supplies. First, self-treatment with inappropriate black-market medications can create severe secondary conditions requiring costly interventions. Often, these individuals are later seen by professionals practicing in the western health care system. Second, the misuse of medications can also lead to the development of drug resistant forms of disease. Such is the case with antibiotics and medications used for the control of leprosy, sexually transmitted diseases and tuberculosis. Third, those individuals within the western health system requiring treatment with medications which have been stolen, are unable to have their disease conditions treated

effectively. This often leads to repeat visits to the health system and more costly cures, requiring additional family resources. Fourth, individuals in the community with meagre health resources, pay substantial fees for medications which may be out-dated or inappropriate for the condition they are being treated for.

The **Emerging Health Care System** consists of a blend of traditional and western health care systems, the result of cultural contact between expatriates and indigenous peoples. The system incorporates chemists, native nurses, traditional birth attendants, auxiliary health workers, and faith healers, all of whom offer healing alternatives representing some degree of "balance" between traditional and western health care knowledge and/or services.

Chemists, selling pharmaceuticals in all available forms, offer information on medications sold, ranging from route of administration to possible side effects of the drug. Seldom prepared with formal training for the job, they sell medications, accepting no responsibility for untoward side effects. Success is not guaranteed

through mere business ownership or prescriptive abilities of the chemist. Rather, competence is best measured by the return of customers; a living testament to the chemist's knowledge, skills and abilities. Chemists during this study were found in close proximity to western health care services and often extended credit to customers thought to be urgently in need of the medication. One villager interviewed for this study had been supplied with anti-inflammatory agents for over 3 years by a chemist who was well aware the client was unable to repay the kindness. In this case, the occasional gift from the client was considered sufficient reimbursement.

A second group of practitioners in the emerging health care system are native nurses. Usually these individuals live within the village and are familiar to greater or lesser degrees with both western and traditional healing therapies. Native nurses have acquired what they believe to be the necessary knowledge and skills to administer these treatments to community members. Knowledge and skill development occur as a result of: 1) some exposure to health training either by

working in acute care settings, 2) a basic interest in the area and obtaining books in which skills are described (IE. "Where There is no Doctor" by D. Werner), or 3) failing out of professional training. Some nurses during this study stated they had been exposed to health care knowledge and skills as domestic staff for health care professionals. Treatment modalities mentioned during interviews consisted of: utilization of basic assessment skills, use of heat and cold therapies, surgical techniques, medications administration (IE. use of injectable and oral pharmaceuticals) and trauma intervention.

Although native nurses are known to the local villagers, they are not "generally acknowledged to exist -- for fear they would be caught and not allowed to practice anymore" (Brink, 1984, p.23). During this study native nurses were seen to treat: abdominal discomforts, headaches, malaria, snake bites, dysentery, embalming, preparation of bodies following death, fever, surgery for superficial skin growths, surgery for hernias, and a variety of other disease conditions. These individuals were normally contacted at their homes

and made house calls. Native nurses participated in all that was part of "normal" village life and therefore were seen as readily accessible and accepting of the **Annang** and their health care beliefs and practices. Native nurses charged nominal fees and quite often accepted gifts in lieu of financial reimbursement.

Traditional birth attendants or native midwives, having learned their trade from mothers or other extended female family members, presently supplement training with knowledge and skill development offered through the primary health care centres. The native midwife is accessed for all aspects of pregnancy including prenatal care, labour, delivery, and antenatal care. This worker offers information to the community members regarding: nutrition, exercise, taboos pre and post-delivery, breast-feeding, treatment of the umbilical cord following birth, and herbal remedies for complications during pregnancy. Although licensed midwives are available to pregnant women in the primary health care centres, few if any women actually have their babies there. Rather, at the time of this study, the most

popular area for childbirth, barring complications, were the churches and prayer houses and then the homes of the prospective mothers. As licensed midwives were seldom accessible to villagers outside of the health centres, native midwives were more often relied upon by the villagers. Fees were paid to the native midwife in **naira** or in the form of gifts. Reputations, and the ensuing economic security for the native midwife are developed with each successful delivery (Brink, 1982).

During 1974-75, on a visit to the **Annang** of **Afaha Obong**, Brink took special note of the role of traditional birth attendants (TBA's) practicing in local villages. At this point in time, Cross River State officials were considering outlawing TBA's and requiring that all pregnant women access only western health care personnel trained in midwifery. Following a report of TBA practices, including recommendations for improving practices which were questionable in TBA's, Brink's report was submitted to state authorities for consideration. As a result, legislation was passed supporting the incorporation of TBA's into the

existing primary health care services. This support included: 1) the initiation of training programs by health care professionals for TBA's which focused on improving prenatal, labour, delivery and antenatal practices; 2) the use of referrals between western and emerging health care systems; 3) the improvement of basic equipment and techniques used by TBA's for delivery purposes; and 4) recognition of the value of lay practitioners in the primary health care system in attempting to meet the expanding needs of the community.

Auxiliary health care workers refers to those individuals who act as cultural brokers between the community and the health care system. This grouping includes community health care representatives, nursing assistants, lay health care educators, interpreters and sanitation and hygiene workers. Although these practitioners were said to be practicing in the **Abak** local government area, on only 2 occasions were they observed. In both cases they were responsible for the cleanliness of the health centres and in assisting the nurses in their health promotion and disease

prevention strategies. The auxiliary health care workers were not observed in the villages during the 1989 field study, nor were they apparent in Brink's 1976 work.

Faith healers treat a variety of illnesses at the village level. Cures may occur either in the individual's home, and/or the church or prayer house. During this study, one middle aged woman suffering mental health problems had been brought by her family to an evangelical church in a small village for a faith cure. The woman was noted during the service to be manacled by the legs to a wooden post in the centre of the church. A small bowl of water and piece of cloth had been left beside her. The woman moaned and cried out for help throughout the service, ignored by adults in the congregation and stared at by the children. Prayers and offerings were later offered for the woman who had been "overcome by evil." When asked how long the faith cure would take for this woman, the researcher was told "it would depend on when the woman would be released by the devil and delivered unto God...God will inform us."

Conditions most commonly treated include mental illness, and/or disease conditions considered incurable by other systems. Although faith healing was reported to be used in conjunction with other forms of healing, for this study, religious cures were sought out in isolation from other healing technologies due to cost and inconvenience to the family. Accordingly, interviews and observations conducted during this study suggest that **Annang** theories and/or explanations of disease and/or illness causation are related to a worldview which is particularly religious.

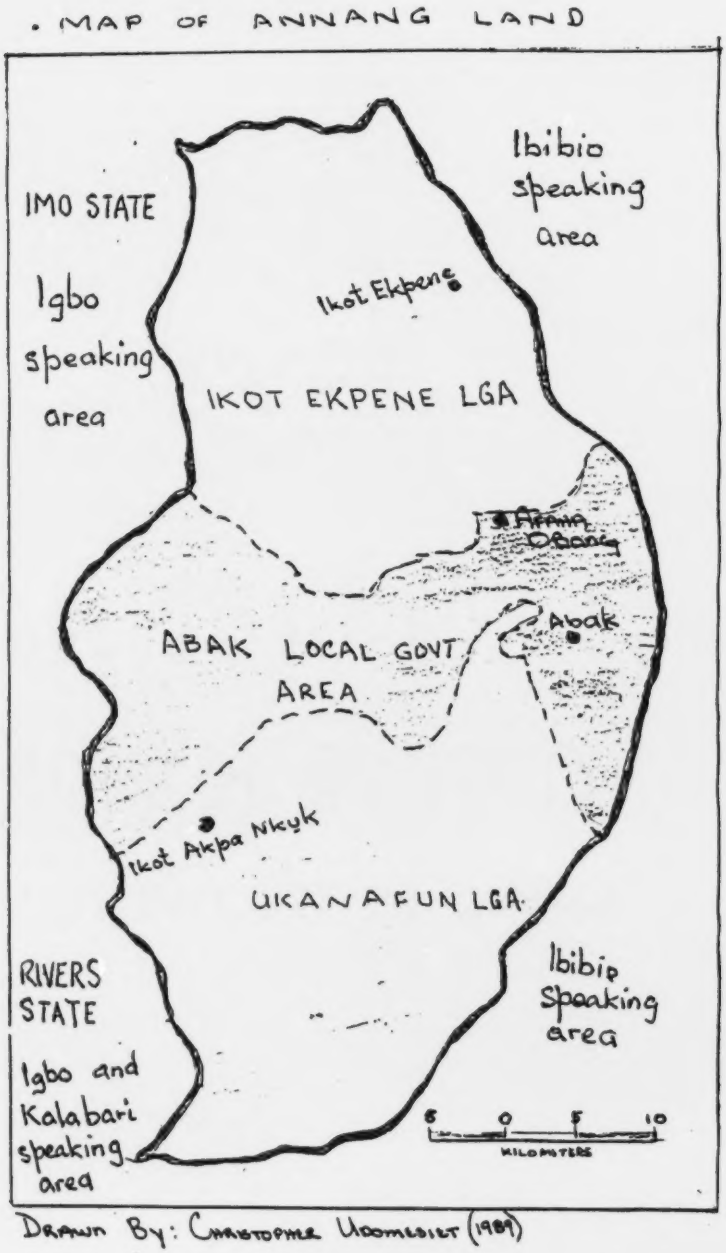
Sample

The study was conducted in the villages of the **Annang**, within **Afaha Obong**, **Akwa Ibom** State (see Figure 1). **Afaha Obong** was selected as it is:

> the crater of the **Annang** people...indeed, any village in **Akwa Ibom** State that has as it's name either the prefix or suffix **"Afaha"** is known to have had it's founding father from **Afaha Obong**...In days of old the people of all **Afaha's** had common festivals...Any important happening was served at **Afaha Obong**...Any important visitor was received at **Afaha Obong**...Any important decision that would concern all the villages, settlements, and clans related to **Afaha** would be taken to **Afaha Obong** and from there would be disseminated to the other **Afaha** villages...this was our history (M. Okaji, personal communication, 1989).

Figure 1

Map of Afaha Obong, Akwa Ibom State



Criteria for Sample Selection

Participants involved in the project:

1. Were considered by village elders, capable of participating in decision-making processes.

2. Had to speak, but not necessarily write, either English and/or **Annang**.

3. Provided a verbal or written informed consent prior to participation in the study.

4. Were individuals referring to themselves as **Annang** and having one parent, usually male, of **Annang** heritage.

A non-probability network sample was chosen because of: (1) previously documented attitudes of suspicion towards strangers by the **Annang**; (2) the difficulty the **Annang** have in discussing their opinions with individuals unfamiliar to them; (3) a greater ability to select informants who would enhance the researcher's understanding of concepts under study as a result of unique knowledge and/or experiences; and (4) respect for the choice of informants **Annang** elders believed were qualified to participate in the research (Tripp-Reimer, 1984; Field and Morse, 1985; Brink, 1984;

Spradley, 1979; Williams, 1967; Whiting, Child & Lambert, 1966).

The sample for the study consisted of 20 **Annang** participants (9 male and 11 female) living in 11 villages within or surrounding **Afaha Obong** (See Table 2). Village representation included, **Abak** Local Government Area, **Ibibit**, **Ikot Odiong**, **Ikot Afaha Adung**, **Ikot Imana**, **Ikot Ibok**, **Afaha Esang**, **Eriam**, and **Utu**. The ages of participants ranged from 21 to 108 years. Mean ages were not calculated due to the approximate ages given by ten informants who did not know the year in which they were born, and/or were born prior to systematic recording of **Annang** births. Twelve informants named Catholicism as their primary religion, 4 Protestantism and 4 did not indicate a religion when asked. Of the four not identifying a religion, one claimed "a belief in **Abasi** (God) but not a formalized religious institution," and one was not asked his religion. The 2 remaining women not claiming a religion are, or have

Table 2
Demographic Information on Annang Participants

Total:	20
Religion:	12 Catholic 4 Protestant 4 No Christian religion 3 (Belief in **Abasi**) 1 (No stated religion)
Age:	Range 21 - 108
Gender:	9 Male 11 Female
Villages:	9
Marital Status:	13 Married 2 (polygamy) 1 Single 6 Widows 5 (polygamous marriages)
Education:	2 Doctoral Preparation 1 Master's Preparation 3 Baccalaureate Degrees 2 Teacher's Certificate 1 Some Post-secondary Schooling 1 Primary Education 10 No formal Education
Number of Children:	14 With Children (Only 1 with no male issue) 3 Families with male children, but total number of children unknown 3 No children
Care of Orphans:	15 Had cared for numerous orphans (from their extended family) 2 Not asked question 3 Not living in family compound

been, celebrants for the "pagan" ceremonies of **Ndam, Ngwongwo,** and **Mbobo** a forbidden practice for Christian church members. The predominant finding of Christian and Animistic participants supports the religious differentiation between north and south Nigeria suggested by the literature.

Thirteen informants were married (2 in polygamous relationships), one was single (a priest), and six were widows (5 from polygamous relationships). Two informants had doctoral preparation, one a master's degree, three baccalaureate degrees, two teacher's college preparation, one some post-secondary education, one primary schooling and ten with no formal education. Fourteen informants had children (only 1 with no male issue), 3 were not asked specifically about numbers of children (although all had families and male issue), and 3 had no children (a priest, a newly married man, and a man having his wife initiated into **Mbobo** for infertility). Fifteen participants had cared for "many" extended family orphans in their own compounds, two were not asked the question, and

three were not living in their own compounds at the time of this interview.

The Annang in Nigerian Context

Nigeria is located in West Africa (see Figure 2) with a total land area of 923, 768 sq. kms. extending 1,127 km. east to west, 1,046 km north to south and having a 774 km Gulf of Guinea coastline (Kuran, 1989). The nation shares international borders with Chad, Cameroon, Benin and Niger. No border conflicts existed during the time of this research.

Nigeria has a population of 100 million people, identifies 412 distinct tribal groups and 250 variant languages. As Utomi of Nigeria has been quoted as saying, "People don't understand how difficult it is to build a nation out of disparate tribal groups... national boundaries were matters of political convenience in the colonial era, and a lot of the civil wars and corruption are a result of that fact" (Cruickshank, 1989, p.1). At present, the nation divides itself into 19 separate states (see Figure 3), and is ruled by a military dictator, President Major General Ibrahim Babangida. Classed as a

Figure 2

MAP OF AFRICA

This map has been removed from this document due to copyright restrictions. The map of Africa presented may be found in the following reference:

Cruickshank, J. (1989). The crushed hopes of a continental giant. Toronto, ON: Toronto Globe and Mail. (October 14th).

Figure 3

MAP OF NIGERIA

This map has been removed from this document due to copyright restrictions. The map of Nigeria presented may be found in the following reference:

Amadi, E. (1982). Nigerian ethics. Ibadan: Heinemann Educational Books (Nigeria) Ltd.

"not-free country" Nigeria is rated as a 5 in political rights and 4 in civil rights (measured on a hierarchical scale, where 1 is the highest and 7 the lowest rating).

Nigeria represents the most southern outpost of Islam in Africa, spread during the 10th to 19th centuries. The dissemination of Islam however, remained limited to the north of the nation, with Christianity predominant in the south. Religious affiliations have had great significance for Nigerian history, with evidence to support northern Muslims dominating politics, development and the economy. Muslims represent 47 per cent of the population, Christians 34 per cent and animists 19 per cent (Kuran, 1989).

Nigeria fell under British influence during the 19th century when trade routes were established by the United Africa Company. During the 1884-85 Berlin conference, Africa was partitioned among European rivals, and former trade areas became recognized jurisdictions of the country controlling trade for that region. In 1886 the company became chartered with the title Royal Niger Company and areas it controlled now became

protectorates. The protectorate relationship between trader and tradee was intended to ensure some degree of participation in the decisions made for governance of each area. By 1899 however, local Nigerian rulers were thought to be inhibiting British control, and what followed was the revoking of the charter and British administration of all territories.

By 1906, the British divided the nation further along north-south, Islamic-Christian lines, with the administration of all Nigeria from the northern protectorate; the south becoming a marginalized colony. A system of indirect rule was established by the first governor Sir Frederick Lugard, ensuring that responsibility for law, order and trade remained with the British, and day-to-day affairs governed by regional Nigerian leaders. What emerged was a system perpetuating economic, religious, educational and political disparities between the two regions.

Years of nationalist pressures by Nigerians led to full independence in 1960. Since that time there has been one civil war (Biafran War 1967-70) resulting in "nearly one million deaths, two

assassinations of heads of state, two successful coups and countless abortive ones" (Kuran, 1989, p.1477).

In 1985, Major-General Ibrahim Babangida came to power, promising economic reform and a return to civil rights. With the collapse of global oil prices in the early 1980's, the government was stripped of its ability to provide basic social services to its people, repay foreign debts, and establish a firm economic foundation in the private sector. Babangida faced an economy "dominated by giant, heavily subsidized, state-owned companies and a federal administration fatally dependent on oil exports for revenue" (Cruikshank, 1989, p.1). Promising economic reform and a return to fundamental civil rights by 1992, Babangida has instituted some of the most unique economic reforms in the developing world. The price on individual citizens, and foreign relations, however has been great, leading to a dependence on the same military interventions Babangida condemned before coming to power.

One of Babangida's most noted reform measures is the Nigerian Structural Adjustment Program which came

into effect in 1986, cutting energy subsidies, imposing censorship laws, collapsing food marketing boards, encouraging the growth of non-oil exports, limiting imports, and allowing the **naira** to float freely against world currencies. By 1988 the **naira** had fallen to one fifth its value in 1980. Per capita incomes dropped from $1,150 to $425 by 1988.

Although the use of rates in research is considered to provide only the broadest measures of a nation's health status, few other Nigerian statistics are available in the literature. Therefore the following statistics provide a general overview to the situation in Nigeria during the period of this research.

Age profiles of Nigeria document a "younging population" trend where 48.3 per cent of the citizens are under 14, 49.3 per cent between 15 and 64 and 2.4 per cent over 65 years of age (Grant, 1987; Fredrikson, 1983). In 1989, the population growth rate was 3.4 per cent per year (5.8 per cent in urban and 2.7 per cent in rural areas) and population doubling time 25 years. The most recent national literacy rates available for Nigeria were 34 per cent in 1983 (45.6 per cent for males and 23 per cent for females) despite a free,

universal and compulsory education plan (Kuran, 1989; Grant, 1987; Oni, 1985).

A firm supporter of the 1978 Declaration of Alma Ata, improvements in areas such as health, education, sanitation, demilitarization, environmental concerns, the status of women, child welfare, and socio-economic improvements have been slow to evolve (Fredrikson, 1983). Gender discrimination exists throughout the nation, with patriarchy and polygamy prevalent in most areas of society. Women are regarded as inferior to men in virtually all fields and subject to a number of discriminatory legal provisions which vary from state to state. The political process at local, regional and national levels is thought to be the major inhibiting factor to "Health For All By the Year 2000 and Beyond." In 1987, the doctor patient ratio was 1:9,591, life expectancy was 50 years, and male and female literacy rates were 54 and 31 percent respectively. Despite a per capita national product of $730 U.S. Nigeria still has an under 5 mortality rate of 182/1000 live births (Grant, 1987). Transportation, and payment for such, has become a luxury few villagers are able

to afford and distances to western health care facilities act as barriers to optimal health care.

The failing Nigerian economy and resulting effects of such, have impacted upon all aspects of national life. Foodstuffs required to help patients maintain, recover, and/or improve their health status, are sold for extraordinary sums in the markets. Whereas in 1984, 10 - 12 cups of "garri" were sold for 1 naira, in 1989 1 naira will buy 1 cup of garri (personal communication, C. Ebong, 1989). In 1987, only 86 percent of the daily caloric requirements were met for the nations citizens. By 1989, United Nations officials estimated "half the country's preschool children suffered from malnutrition" (Cruickshank, 1989, p.1). Fruits and vegetables, unless grown in one's own garden, were rare additions to village meals. It is estimated that only 36 per cent of the population has access to safe drinking water and modest and recent estimates place childhood immunization rates for preventable diseases as low as 20 per cent (Personal Communication, J. Innes, 1990). Combined with malnutrition these conditions

continue to exacerbate morbidity and mortality rates in those who are vulnerable.

As the researcher entered the country in June of 1989, student riots and numerous civilian deaths had forced a closure of many post secondary academic institutions. Strict censorship laws kept the majority of Nigerians ignorant of issues both within and outside of the country. The Tienemann massacre in China occurring only months earlier, was unknown to the civilian population despite similar events occurring in Nigeria. As one participant stated while reflecting on the socio-political status of Nigeria "At present we have two types of hunger in Nigeria: physical and intellectual. Many at the village level will accept starvation as their fate - they know no better...but for those who know there are other alternatives to the way we are presently living - there is no respite from our hunger."

CHAPTER III

Data Collection Methods

Design

A descriptive/ethnographic design using case studies with semi-structured interviews, a demographic questionnaire, participant observations, and photography, served to identify the means by which health care decisions as well as ethical decisions were made by the **Annang**. Informal interviews, visits to health care facilities and archival materials served to substantiate and expand upon data identified through the case studies and interviews (Lawless, Sutlive and Zamora, 1983; Crane and Angrosino, 1974; Whiting, Child, and Lambert, 1966; Williams, 1967).

The purpose in using a descriptive/ ethnographic design for the **Annang** was to describe in depth concepts forming the basis for health care decision-making and ethical decision-making in a population for which this information is presently unavailable (Messenger, 1959; Forde and Jones, 1950; Field and Morse, 1985; Spradley, 1979; Benoliel, 1984). The prospective nature of

the study was advantageous for the Annang who place value on historical events but on occasion have been known to unintentionally relay inaccurate information (Brink, 1984, 1976a, 1976b; Noah, no date). Limitations of the study design are discussed in the delimitation section of this thesis.

Methods

The study was conducted in four stages. Stage I encompassed all preparations prior to departure for Nigeria. This included the literature review, reading of all available field notes from previous studies among the **Annang**, design of case studies, correspondence with project facilitators in Nigeria, proposal defense, ethical review (see Appendix G), health prevention measures, purchase of field materials and gifts for participants and research assistants. Stage II involved a one week pilot study where the researcher set up residence in **Afaha Obong**, trained interpreters, obtained consents from village leaders, translated case studies into **Annang**, and conducted formal interviews in order to identify and revise inadequacies in the study design. Stage III

encompassed data collection, the transcription of audio-recorded interviews into English, initial data analysis, photography, documentation of participant observations, and archival searches in nearby educational and health care facilities. Stage IV involved data analysis occurring after the researcher returned to Canada, preparation of the final report and dissemination of the results.

Instrument

Although Kilner (1984, 1983, 1981), used an interview schedule to elicit information regarding the allocation of scare lifesaving medical resources amongst the Akamba of Kenya, the schedule required an in-depth understanding of western medical technologies and was considered inappropriate for use with **Annang** villagers given their average levels of primary education (Essien, 1980; Udo, 1983a). Another limitation to this specific instrument is that it may lead informants to discuss western health care interventions at the exclusion of alternative healing options, thereby inhibiting the process it sets out to explore.

Due to the lack of available research on ethical decision-making in health care situations cross-culturally, the development of a specific instrument for the **Annang** appeared to be a pragmatic means of obtaining rich description from study participants. By using semi-structured interviews, the investigator explored views on health care decision-making processes through dialogue; a skill for which the **Annang** have long been respected (Essien, 1980; Udo, 1983a; Udo, 1983b). The case studies were also an entree into subsequent conversations with the **Annang**, exploring a variety of topics which provided background information for decision-making processes in general.

The instrument designed for the descriptive phase of this project contained five case studies, each accompanied by a semi-structured interview and a demographic questionnaire (See Appendices A & E). The case studies were derived from field notes compiled by Brink during 1974 and 1975 from which a health care decision-making model was later advanced for the **Annang** (Brink 1976). The case studies illustrate health care situations in

which decision-making has been required by the **Annang** in the past. Issues explored through the use of the semi-structured interview schedule include: 1) identification of the issue requiring redress in each example; 2) who makes the decision; 3) how do economics impact on the decision-making process; 4) how does the decision vary for men versus women, the young and old, the married and unmarried, those with children and those without children; 5) how does village status affect the decision; and 6) in which circumstances does individual versus family decision-making occur.

The use of case studies based upon previous **Annang** health care situations was believed to ensure the: 1) focus of discussions was relevant for participants, 2) ethnocentric bias of the researcher was minimized, and 3) researcher capitalized on oral traditions of the **Annang**, where stories and/or proverbs are used to convey the values and beliefs of their people (Apostel, 1981; Essien, 1980; Field and Morse, 1985; Foster, 1978; Messenger, 1957; Simmons, 1958a, 1958b; Williams, 1967; Whiting, Child and Lambert, 1966).

The study instrument was developed by the researcher following the literature review process. Approval of case studies and semi-structured interviews was received from thesis committee members who are experts in the areas of ethics (Dr. J. Dossetor), the **Annang** (Dr. P. Brink), African studies (Dr. J. Ross). The interviews accompanying the case studies were considered the most practical way of eliciting rich information given the time the researcher had in the field, the historical practice of family-based decision-making amongst the **Annang**, and field work inexperience of the researcher.

Demographic data (see Appendix E) collected by the researcher included: education, religious affiliation, age, marital status, gender, number of (if any) children, husband's village, paternal village, maternal village, and options for health care most often utilized by informant. These factors are believed to have a significant impact on the decision-making processes of any cultural group. The **Annang** were thought to be no exception.

Data Collection

Prior to obtaining informed consent from individual participants, the researcher met and obtained permission from the Paramount Ruler of the **Annang**, Pastor E.A.U. Arthur, and the Clanhead of the **Afaha Obong Annang** Chief Sunday Udohden. During these meetings, key phrases were spoken which influenced all subsequent field work:

> I have no objection for you to find out as much as you like if you follow the rules and traditions of **Annang**, which you must when you are going with people like this (motioning to Rev. Father Dr. Umoren and Mr. Emanuel Sade)...They know what to do and what not to do...Document the **Annang** before all is changed and gone the way of **mbobo**...we want the world to know exactly what we are, as I think we have lost so much (Paramount Ruler, Pastor E.A.U. Arthur).

Formal study interviews began the same day permission was received by tribal elders and were simultaneously translated to the researcher by one interpreter, fluent in English and **Annang**, who acted as an intermediary for the discussion of case studies. Informal interviews were conducted in the same manner. All interviews were audio-recorded except for those participants refusing to have their "words taken away" on tape. In those instances detailed field notes were completed by the researcher. In both informal and formal

interviews, attempts were made to ensure that information revealed in one aspect of the study was not revealed in another. This issue was reinforced with interpreters during Stage II as well as throughout the study when applicable. Whenever possible informal interviewees were different from those participating in the formal interviews.

Data Analysis

Data collected during the interview period of the field study was reviewed at the end of each day in order to identify areas requiring more in-depth information and to capitalize on the availability of experts in the field. Probing, exploring and expanding upon topic areas was conducted throughout the interviewing and observational periods in order to identify and saturate topic areas. **Annang** experts in the **Afaha Obong** area were consulted on a daily basis in order to verify categories identified in interviews and field observations. Although a number of topic areas were saturated prior to the researcher's departure from the field, the true

determinant of study completion was the limited eight week stay in Nigeria.

Content analysis was utilized during the study and after leaving the field in order to organize, categorize and code data. Categories were clearly identified and related to the data. Persistent themes became apparent and were validated during successive interviews/ observations.

In Canada, following transcription of interviews, sorting of categories was performed using cut and paste techniques. Examples of decision-making were identified and met Gladwins (1989) criteria for decision-making: an area of uncertainty, a set of alternatives from which to choose, criteria by which the choices are evaluated, and an eventual choice between alternatives. From this group of decisions, those which were ethical in nature were selected out for a more indepth analysis. Ethical decisions were deemed to be those in which: individuals were committed to good, there was knowledge of relevant facts, individuals involved had clarity in dealing with the issues, and principles guided the

decision-making process (Reid, 1992; Storch, 1982). The decision-making examples were later organized into ethnographic decision tree models (Gladwin, 1989), and submitted to the scrutiny of the thesis chair who assessed the degree to which examples reflected "emic" decision-making. The object of this process was to "discover the cultural meaning of the insiders' relationships, native terms, rules, and way of life" (Spradley, 1979, p.3).

Frequency counts were used to describe the collection of demographic data, responses to case studies, and order in which **Annang** informants access health care services in their community.

Reliability and Validity

Reliability and validity of field research remains a contentious issue in health and social science literature. It is believed however, that the more time a researcher spends with a variant cultural group, the more their values and beliefs come to be understood, thereby enhancing the validity of the data (Brink, 1991; Pelto and Pelto, 1978).

The test of validity for field work rests in how accurately the researcher is able to describe the reality of the culture under study and the subsequent reporting of this reality in the research report (Field and Morse, 1985). Therefore, during the field study, nightly discussions regarding data took place with **Annang** elders in order to clarify information and identify areas which needed further exploration. In this way, an attempt was made to portray the means by which health care decisions were reached amongst the **Afaha Obong Annang** of Nigeria.

Face validity in field research assumes that informants are experts on their culture (Brink & Wood, 1988; Field & Morse, 1985; Lawless, Sutlive & Zamora, 1983). Content validity of the data was verified through a process of consensus during group interviews. Where individuals were interviewed, validity was ascertained through: 1) successive verification of detailed field notes with as many cultural informants as necessary, in order to discover implicit and explicit cultural meanings, and 2) with experts on **Annang** culture in both Nigeria and Canada.

External validity or generalizability assumes action and experience are context-free (Mishler, 1979). In descriptive field research however, the object of the study is to translate the "native's view" into words of other communities. Therefore, generalizability conflicts with descriptive field research, which emphasizes the study of phenomena in natural settings (Sandelowski, 1986; Aamodt, 1982; Yoder, 1982). As a result, the concepts of adequacy and appropriateness were used as evaluation criteria for this study (Morse, 1986). As "rich description" from selected cultural informants was sought and access to participants was often determined by factors external to the study, a non-probability network sample was deemed appropriate. Adequacy was determined at the end of the study by assessing quality, amount, completeness and richness of information yielded in interviews and corresponding field observations (Brink and Wood, 1988; Burns and Grove, 1987; Crane and Angrosino, 1974; Field and Morse, 1985).

As the case studies and interview schedule developed for this study had not been previously tested, reliability measures were non-existent.

With regards to the validity of the instrument, it is was demonstrated that although informants could relate to the case studies, interview questions did not engage their imaginations. This phenomenon is believed to have been responsible for the yield of data which was unvaried and superficial in content. Although each case reflected real life situations experienced by the **Annang** and documented by Brink in 1974-75, and despite the author's observations of similar situations in the **Annang** field study of 1989, the **Annang** were unable to relate to the tool. The research instrument was therefore deemed invalid. This finding may suggest that the instrument is either irrelevant, and/or inappropriate for examining ethical decision-making processes in cross-cultural groups similar to the Annang.

Interpreters were essential in dealing with the communication barriers between the researcher and study participants. The use of interpreters however, has previously been implicated in the systematic alteration of interview questions and responses (Field and Morse, 1985; Burns and Grove, 1987; Kulig, 1987). Therefore, during Stage II study questions were translated into

Annang and administered to those participants identifying **Annang** as their preferred language. Training of **Annang** interpreters during this period reinforced the need for exact translations of the questions and answers, including both verbal and nonverbal subtleties (Field and Morse, 1985; Morse, 1986). Stage II also involved educating interpreters with regards to: 1) confidentiality, 2) anonymity for village informants, and 3) the importance of obtaining information for the study in a manner free of coercion. Translation of the interviews was done by one **Annang** interpreter at the time of the interview and a back translation into English by a second interpreter done from the audio-recording following the interview, to ensure the accuracy of the previous translation. This was one method of minimizing the variation of interpretation occurring in the translation process. Inter-rater reliability and validity was accomplished by re-coding categories of meaning by an observer after confirmation of the categories with the subjects themselves (Morse, 1986; Brink and Wood, 1988).

As the case studies and semi-structured interviews were designed for the present study, no measures of reliability and validity exist.

Therefore, participant observations, informal interviews, and library searches, were used in attempt an to validate the information yielded through use of the study instrument.

Ethical Considerations

Previous Nigerian research endeavors have revealed "the **Afaha Obong Annang** do not wish to have anonymity or confidentiality. They would like the world to know about them by name" (Brink, 1989b, p.6). With respect to these views, names of all informants were recorded and used for the purposes of audio-taping, transcriptions and subsequent data analysis for the study. The possible omission of the village name, presented certain difficulties, as the researcher believed this information was essential in revealing unique differences in decision-making amongst the **Annang**. Therefore, informants were also identified by present, paternal and maternal villages.

Historically, all major decision-making amongst the extended **Annang** family system has been the responsibility of the **akpan** (senior male). For this reason, permission to conduct the study in each of the individual villages was first obtained

from the designated "headship" of the lineage. Although permission from the headship of the village is accepted by the **Annang** as consent for all, ethical clearance for the project was given with the proviso that individual consent also be obtained (see Appendix G). Therefore the researcher obtained informed voluntary consent from each informant, at which time a description of the study was available for the participant to read in either **Annang** or English. If the informant was unable to read the study description and/or the consent in one of the available languages, an interpreter read the forms to him/her in their entirety in the language of the participant's choice. For those individuals unable to write their name on the consent form, an X was accepted, provided a literate **Annang** witness overhearing the study description was present to sign the consent form.

Technical terms, where possible, were avoided in both the study description and consent form, as rural Nigerians, given the chance to attend school, are often limited to primary education offered through the Universal Primary Education

Program (Cruickshank, 1989; Kuran, 1987; Olukoya, 1986; Oni, 1985; Udo, 1983a, 1983b; Mba, 1982; Balabkins, 1982). Consenting participants were informed of their right to withdraw from the study at any time without fear of penalty, receiving one copy of the signed consent form from the researcher. Those unable to understand the purpose of the study, or who were deemed to be incompetent by family and/or village consensus, were excluded from the study entirely.

A duplicate listing of names of informants, family lineage and the name of the village in which the interview was conducted, were kept in a separate location from the response sheets and data analysis while in the field. Upon return to Canada the data was kept in a confidential and secure location in the researcher's home. Permission to keep transcriptions and audio-tapes for an indefinite period of time for secondary data analysis and/or subsequent research projects was obtained with each individual consent. At the conclusion of the study, participants have been told they will be provided with feedback through

verbal and written summaries, in both English and **Annang**.

The practice of gift giving is an honored tradition for the **Afaha Obong Annang** (Brink, 1989, 1976). For this reason, on all occasions where a formal visit was made to a village member, a gift was required. This practice is not considered by the **Annang** to be bribery, but rather a sign of respect to the head of the household. Gifts most often exchanged included fruit, beverages, cloth, tobacco, and/or vegetables, dependent upon the status of the individual being interviewed.

Information collected on previous **Annang** research projects is considered a permanent historical record of their people (Brink, 1989). Therefore, all information collected during the eight week study will be added to **Annang** archival materials presently being accumulated by Dr. Brink of the University of Alberta, and donated to the **Annang** for use in historical research upon her death. Future access to information collected by the researcher during the study has been assured through a written agreement with Dr. Brink (see Appendix F).

The study is expected to contribute to knowledge by further delineating the unique role cross-cultural values and beliefs may play in the health care decision-making process. In addition, through photographic, audio and written documentation of the **Afaha Obong Annang**, the author will be complying with previously recorded desires to have "**Annang** ways" preserved for future clan members as well as other people around the world. Perceived risks of the study included health risks for the principle investigator, which given all reasonable precautions, could in no way be predicted with certainty. The major risk associated with the study for the **Annang** was that demographic information collected during the study, would represent perhaps the most recent census of the area since 1963. Some villagers believed that if government officials were to gain access to field notes, the village tax base could be increased (Brink, 1989). For this reason, government officials will not have voluntary access to the field notes of this study, until they become part of the archival records of the **Annang** following Dr. Brink's death. The ethical

guidelines of the Canadian Nurses Association were adhered to throughout the study.

CHAPTER IV

Findings

Annang Decision-Making

The findings of this research are discussed in three sections. First, examples of Annang decision-making, based on participant observation in the field are described. Second, responses to prepared case studies are outlined (see Appendix A). Finally, respondent choices related to access of health care services/personnel, for themselves, and family members are detailed. The three data sets juxtapose the differences between "ideal" and "real" decision-making, by illustrating the way the **Annang**: 1) believe health care resources "ought" to be utilized; 2) describe how they access health resources in their own community; and 3) actually decide and meet health care needs within their cultural milieu.

Annang Decision-Making as Witnessed Through Participant Observation

Through the process of participant observation in all activities of the study, the researcher was able to document 150 examples of **Annang** family decision-making. These examples were

then analyzed and sorted according to Gladwin's 1989 criteria for decision-making: a) a point of uncertainty, b) a set of alternatives from which to make a decision, and c) a choice between the alternatives which ends the uncertainty. Those examples which did not meet all aspects of the criteria were set aside. Although not all examples reported in the following section reflect health care and/or ethical decision-making situations, they do detail the family-based decision-making processes of the **Annang**. The expanded examination of areas in which decision-making occurred, was believed to enhance the understanding of the rationale for decision-making outcomes in health related areas of the study.

Brink (1976) has asserted that most decisions related to health care utilization by the **Annang** are made within the family unit. In the present study this assertion was validated, except in two instances. First, when an individual's belief in religious powers superceded those of the extended family and health care decision-making became the domain of the so called "spiritual leader." This led to an abdication of the health care decision-

making role by the family **akpan** and assumption of directives for health interventions by the "healer". The family decision-making role was resumed only after the patient had completed the treatment recommended by the healer. Second, the family gave up decision-making powers when health care needs were of an emergent nature. Two such cases were documented, one in which an **akpan** was deliberately hit by a car and required emergency care at a hospital and the second case, an infant (also **akpan**) hemorrhaging following a village circumcision who also required hospitalization. In both situations, the normal health care decision-making process was circumvented in attempts to meet the acute needs of the individual. Additionally, both individuals who circumvented the family decision-making process were: males, as well as family **akpan's**.

Eight examples of decision-making are detailed in this section. They exemplify **Annang** decision-making for issues such as: promiscuity, breaking **Annang** social taboos, infertility, individual versus family decision-making in the area of career, productivity and family resource

allocation for the aged, selection of healers, and resource allocation within the extended family hierarchy. Additional decision-making examples documented but not reported in this study included: family inheritance (2); marital separation (3); securing basic needs when widowed with children (2); assessing virginal status of **mbobo** candidates (5); and, securing a family **akpan** versus adhering to Christian doctrines (4). Although the eight situations reported could be placed within an ethical framework, the **Annang** were at no time seen to do so. The **Annang** saw their decision-making responsibilities as pragmatic means to family ends.

Annang Example One

The first example documents the decision-making process of an 80 year old woman suffering the effects of cardiovascular insufficiency, an abdominal hernia, and arthritis. Although the woman complained continuously of joint pain, abdominal discomfort, dizziness, fatigue, weakness, shortness of breath, and difficulty completing tasks, the illness was not believed to be critical in nature by the family. Nor did the

family believe the woman, in late life and who was seldom productive, required resource expenditure. The woman stated her family felt their meagre resources were better left for those who had greater productivity capabilities for the family. Furthermore, the woman was not experiencing a sufficient degree of functional impairment or pain, still capable of tending small children in the compound, preparing meals, washing clothes and weeding the garden. Her status in the family had improved with age but diminished somewhat with the onset of menopause and the subsequent loss of reproductive capabilities. Her husband was no longer alive to support her, and she was incapable of trading goods in the market as she had done for most of her life. Therefore direct economic contributions to the extended family unit were absent. As only one member of the immediate family was working, resources were limited and access to health care resources was denied. In this case the woman had sought out the assistance of someone from the emerging health system who had offered on credit, "green pills," self-administered and occasionally effective in providing symptom

control. The woman stated that daily prayer was part of her life, and that hope of intervention had faded. She had not pursued a reversal of the family decision for many years. This example illustrates how productivity is a major factor in decisions which require family resource expenditure.

Annang Example Two

A second example illustrates the selection of a healer by an "**Idiong** man" who became ill during this study with-malarial fever, aches, joint pain and general malaise. Not a strong supporter of western health care services, the **Idiong** man selected a native nurse from the emerging health care system, known in the community to make house calls and respected for his healing abilities. The native nurse had his own mode of transportation which saved the family of the **Idiong** man the trouble and expense of travel. The native nurse carried his own supplies and was trusted for his diagnostic capabilities, knowledge of treatment modalities, success with other patients, lack of concern about monetary reimbursement, and general acceptance of a variety of illness conditions in the patients he served. No apparent patient teaching

however accompanied the treatments which could have shown the **Idiong** man how to minimize the effects of the symptoms. Following a series of injections received from the native nurse, the **Idiong** man had in his estimation made no significant improvement. The researcher, who was a nurse, saw the **Idiong** man one day later. During interviews, it was suggested by **Annang** research assistants, that the **Idiong** man speak to "the white woman from Canada about how he might control his discomfort, as they had witnessed her healing powers in other areas of the community." After some hesitation, the **Idiong** man requested assistance from the researcher, who made a number of simple recommendations, reinforced with patient teaching. Two weeks later, on another interview with the **Idiong** man, the researcher was presented with gifts and thanks, for the interventions which had subdued the effects of the malarial bout. The **Idiong** man stated "Just as I have powers for healing, I have learned that so too do you...you will be the healer I access until your departure." The **Idiong** man in this example shows how healers are chosen in the community. Each healer is believed to have unique healing powers separate from other healers. Your reputation precedes you, and is

carefully evaluated when individuals consider whether they will access your services or not.

Annang Example Three

Another example of **Annang** decision-making is that of a young woman who remained barren following four years of marriage. The young woman, once promised in marriage, had commanded a significant bride price from the husband to be. Bride price is seen in the **Annang** culture as compensation for the gift of fertility and potential to bear "**Akpan**". It is the bride's major responsibility to provide "male issue" who in-turn will inherit the father's wealth and ensure the continuation of the family lineage. During four years of marriage the bride remained barren and was taken to a native healer who, after negotiating with her mother (responsible for her child-bearing abilities), treated her with native remedies and therapies. The woman was returned to the husband's compound and was expected to produce male issue within the year. She did not and was subsequently treated by a series of other native healers known for their prowess in treating "barren women". At no time was the husband

investigated as a possible reason for the couple's childlessness. The researcher of this study met the woman during year 6 of her married life. The woman's appearance was masculine, having a thin beard on her chin (a trait highly sought after by eligible bachelors), a deep voice, and heavy musculature in her extremities. The woman stated she had not experienced menses for perhaps 9 years. Although in this situation the woman had not been treated by the western health care system for her obvious hormonal imbalance, she had been treated by traditional practitioners who said she was cured of her "barrenness." The patient looked and acted well, performing other wifely duties adequately. During this research project, the woman's husband had considering seeking a new wife to produce children, and her mother had come to the conclusion that no other treatment would be of use. Rather, they now believe that in a previous life, she has perpetrated some heinous crime against children, and is prevented in this life from having such an opportunity again. The case shows the value placed on "getting **akpan**" in the **Annang** community. A woman's worth is to a large

degree based on her ability to provide "male issue." Men are seldom seen to be the cause of a couple's infertility. When confronting such infertility, and the question of a continued family lineage, the woman is investigated with the communities blessing. This example highlights the resource expenditure a family will designate for the purposes of "getting **akpan**."

Annang Example Four

One specific example illustrates effectively how the **Annang** distribute economic resources to family members. The family had 5 children all of whom were in school. The father in the family, was the **akpan** for his extended family system, and after his father's death, had assumed all debts and responsibilities for his siblings and their children. The father was employed at an the educational facility, the mother in a health facility. The eldest male child was attending school outside of Nigeria, the second eldest was in the seminary, one daughter was in law school and two younger children in the private school system. The father's younger brother was also attending school abroad, however scarce family

resources had forced the father to decide upon which family member (his brother or his eldest son) was to return from overseas and perhaps forfeit their degree. The decision was to have the father's son return and attempt to complete the degree within Nigeria; the majority of resources being invested in the father's brother. As stated by one family member: "In **Annang** culture, your responsibility is to brothers and sisters first...then towards your own children and then to your brother's and sister's children." This example illustrates the order in which resource allocation is distributed within the **Annang** family hierarchy.

Annang Example Five

During the study, the issue of promiscuity of the youth was discussed at some length. One case was witnessed where a young high school student had become pregnant and the family was deciding what course of action would be chosen. The family believed that many boys were "trying partners," because they are only allowed to marry once in the Christian religion, not many times as in the **Annang** tradition. Therefore, having a woman who

could become pregnant and bear issue was of great importance. This girl's family had a number of alternatives from which to choose. The girl could remain at home and bear the child on her own. In this case, the child would carry the mother's maiden name for it's entire life and have no claim to the father's inheritance. Such a circumstance is believed to be a "curse for an **Annang** child." Second the girl could go to the boy's home and live with his family, marrying after the arrival of the child. A third option would be to travel to a native midwife or to the city for an abortion, but the family believed that abortion was murder, and illegitimate pregnancy a important social deterrent. For this reason, girls must go through a pregnancy out of wedlock and suffer the comments in the community. She must also endure the punishment that would be hers during the season of **Ekpo** (a period of masquerade when crimes against the **Annang** society are paid back in retribution by a unknown assailants). The father in consultation with the boy and his father decided the girl would go and live in the boy's compound and marry following the delivery of the child. The parents

discussed the fact that promiscuity seldom occurred in past generations, as all young girls went through the female initiation ceremonies during which time, virginity would be established by the female celebrants involved. Non-virgins did not command a high bride price, lost respect in their social environs and were barred entrance to the women's societies. Girls caught lying about their virginal status during initiation into the women's societies were often stated to have died "six months following their walk in the ancestral field." With the advent of Christianity, the female initiation rights were outlawed, **Annang** traditions were kept out of the school system, and moral behaviour dictated by a religious body which was not understood by the community. Initially a society motivated by strict moral codes and harsh penalty systems, the **Annang** were reduced to a tribal group whose sexual prowess was not accompanied by social responsibility. Today many parents, such as the ones in this case are faced with the decision of what to do with daughters becoming pregnant out of wedlock.

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> ...there was great family opposition... here is an **akpan** - an educated person and he should stay home and raise a family and continue the name of the family...I would have to be responsible for the things happening in my family - in the **ekpuk**...I would have to help make decisions - protect the family name and family property - no other person would have that right - not even the second son would have the respect an **akpan** would get...I wasn't aware of the problems until many years into the seminary.

This case highlights the value of **akpan** in the **Annang** community and the rare exception to **akpan** assuming a position in which allegiance to family is sacrificed for personal and/or spiritual goals.

Annang Example Seven

The degree to which the extended family supports members is illustrated in the case of a women who was blind, her son who was infirm and had a severe skin disorder, and a daughter who suffered from a psychiatric disorder. The woman's husband had died some years back and the surviving family members remained in the paternal village attempting to meet their needs. The family had a small hut, and the two children attempted to meet the basic needs of food, shelter, water and clothing for their mother and themselves. All three were unable to work and so were dependent upon members of the **ekpuk** (extended family) for

assistance. The only member of the family who could claim the father's property was the son, and he was not of an age to manage this responsibility. The options for this family were to return to the mother's village and have her family support them, or to remain in the husband's village and depend on the extended family system. The choice made by this family was to remain in the father's village where in future the son would be able to claim the inheritance of the father. When the extended family was asked if any other options existed, they said no, as friends will only support you for a short period of time, the church, they believed, would not support a family as destitute as themselves and for the length of time they would need assistance, and begging was forbidden amongst the **Annang** as a means of survival. Returning to the woman's village was not seen to be a viable option as the son's inheritance may be divided between surviving male members of the father's family, unable to be claimed at a later date by the true family **akpan**.

Annang Example Eight

One final decision-making example illustrates how the **Annang** deal with family members who break social taboos. Theft, historically as well as at the present time, is believed by the **Annang** to be "caused by the blood." Children inherit this trait through the family lineage. Stealing is considered, along with murder and incest, to be a basic **Annang** taboo and brings about stigmatization of the family, affecting generations past, present and future. "In a community where meeting family needs depends on severe family rationing of resources - we tolerate no one who jeopardizes the precarious balance we maintain with our environment...perhaps children are dealt with more leniently the first time, but adults can suffer severe penalties for breaking this social code" (C.Ebong, 1989). Penalties for stealing now, as in the past, are harsh including: "social death," family neglect, physical beatings, and loss of life. This was illustrated in the case where an elderly woman in the community was known to have stolen goods from the village market and also vegetables from the gardens of her neighbors and

extended family members. As the woman had not asked for the goods, which would have allowed the community to respond to her needs, she was named a village thief. Her family members were known to be wealthy individuals, comparatively speaking, and her actions were less tolerable as a result. She was deemed to be neither a confused individual or needy. Following her actions, family members did not speak to, or of her. Neither were they seen with her in the community. She had selectively been ostracized from the family group and refused further family resources for health concerns. The woman died as a result of unmet health needs during the time of this study and was provided a non-ceremonious funeral. At the time of the researchers departure from the field, family members were meeting to discuss the prospects of a second burial, a right of passage afforded all respected members of the community. The family also feared community recriminations and retribution during the upcoming season of **Ekpo**.

Informant Responses to Case Studies

Initially thought to be an innovative, reliable and valid means of obtaining rich information from study participants, the use of the case study instrument proved to be a dismal failure in field conditions (see Appendix A). During the first five interviews, **Annang** participants were questioned thoroughly about their answers to the case studies and rationale underlying the decisions made. Saturation of categories occurred early in the interviews and no variability in responses was offered by subsequent informants. In consultation with the field supervisor, indepth questioning of informants ceased following the fourth interview and all subsequent responses were then organized according to case study, question and categories isolated during the first four interviews. The presentation of responses is organized according to question and categories of responses in the following section.

When asked who is the most likely individual to decide what may be wrong with a family member, participants agreed that the domain of diagnostics

is not for the lay-person, rather, this area is left to experts such as the **Idiong** man (who consults with the oracle), native doctor, or in some cases a hospital doctor. Women, as well as other family members may identify symptoms and report such to the senior male in the family, but they are not to decide what is right or wrong in each situation. Neither are women to give consideration to matters outside of their own family unit. The only exceptions to this rule would be: women trained in native medicine or healing such as a celebrant for **ndam**, **ngwongwo** or **mbobo**; women who are faith healers; traditional birth attendants; and/or those women with professional health care training. Informants did however deem themselves to be capable of observing signs and symptoms of an illness which then validated such for other members of the family.

When asked who takes the responsibility for deciding how the sick person will be cared for, informants (of all ages and genders) were unanimous in agreeing that health care decision-making is the responsibility of the **akpan** (senior male member) of the family. Participants also

achieved consensus when stating that although decision-making is an important goal, the family process from which the decision comes, is of greater significance to the family.

> In all cases, respect for family: authority, rules, roles, age groups, responsibility, and status, must be adhered to - for this is the environment into which one is born, lives, is cared for, and dies...to betray this order as an individual, at any time, is to betray the family, as well as place in jeopardy, future chances for assistance in times of need (C. Ebong, 1989).

When asked what the most favourable outcome for each scenario would be, informants, gave what the researcher and thesis committee believed to be the "ideal" answer: all individuals receive equal treatment regardless of gender, age, social status, child bearing capabilities, order in which resources are requested, and marital status. As one informant stated "All people are treated the same in **Annang** land" (E. Sade, 1989). Informant responses to this question were of interest, as the case studies had been derived from participant observations amongst the **Annang** recorded by Brink between 1974-75. The specific examples had stood out in the field notes, having detailed that: gender, age, social status, fecundity and

fertility, timing, and marital status, had everything to do with health care decisions and outcomes for the **Annang**.

The only variable expanded upon by informants was that of economics and this led to subsequent discussions of "family indebtedness." **Annang** informants stated, that the economy was a major factor in deciding who would be treated for a health concern, how they would be treated and for how long. Informants believed this had not been true to the same degree previously. "In 1984 - we could buy 12 cups of **garri** for 1 **naira** - today we can buy 1 cup of **garri** for 1 **naira**. To say that economics does not determine how we meet our health care needs is to deny reality. Our family structure must be strong and unyielding. Without this structure - there is nothing else - no other social welfare institutions or charitable agencies to help us" (R. Udomesiet, 1989). The researcher notes that in the field notes of Brink collected between 1974-75, economics were also perceived to be a factor in health care decision-making issues, as evidence in the scenarios illustrated by the case studies in this research.

When asked how economics impacts on health care decision-making, informants stated that as a family member (nuclear and extended), whatever resources are available to you, become those of the family. Numerous times during interviews, informants repeated a proverb used in their community: "The cleaner of the sick room's mess has less gratitude than the donor of a small amount of money to pay the bills" (Essien, 1980, p.81). This proverb apparently highlighted for **Annang** informants the importance of financial aid as opposed to caring and comforting behaviours which loved ones might demonstrate towards the sick. The proverb also illustrates the profound value the **Annang** place on productive, financially soluble individuals and the communal ownership of, and access to, said individual's economic resources.

If a sick person has no economic resources, they look to the **akpan** in the family who is responsible for decision-making. Other members of the **ekpuk** are then solicited by this person for assistance in dealing with the family matter. If the **ekpuk** has no immediate financing available to resolve the health issue and the

person is believed to warrant intervention, the matter will be decided upon at a larger family meeting (attended only by males). Following this point, each **akpan** in the family will return to their compound and attempt to locate funds. This may be achieved by selling personal belongings, calling in debts owed to you by others in your network of family and/or friends, or borrowing money yourself. This is the way in which the **Annang** secure family indebtedness:

> You are called on to assist in a family matter... You lend the money and then the family is indebted to you...You now have resources invested in the family, which keeps you close, in order that your investment will be returned...The system is reciprocal in nature, the independent variable being when your investment is returned...If any member of the family requires assistance, it is not charity which leads you to intervene. You assist because it is your family duty or obligation. You must assist, knowing that unless you comply with family requests, you will be ostracized and in jeopardy of not receiving assistance if you or your own family require such in the future. This ensures that the cycle of indebtedness is not broken (C. Ebong, 1989).

Health Care Resource Selection By The Annang

Having asked the **Annang** to tell the researcher how they would make health care decision for others in their community (through the case studies), the participants were then asked to state how they met their own health care needs. This was done through the use of the

demographic data information sheet, where participants were asked what health care resources they normally access for their own personal health care needs (see Appendix E). The following discussion identifies the process of decision-making they state they use for themselves and their family.

All participants stated they begin the health care decision-making process by validating their illness to themselves through symptom identification. If the symptoms are severe enough to interrupt their ability to function in the family and perform their assigned tasks, they begin a process of self-treatment. This may include the application of cool clothes, herbal drinks, eating clay, cessation of activities, increased rest, fasts, etc. Fourteen of the informants state an integral phase of the decision-making process is prayer; a hope for a reduction in symptoms, although some prayed to **Abasi** (God) and others to Christian dieties. The women followed this process by approaching the **akpan** of the family to validate they were ill. The priest sought instruction from his bishop, and

those informants who were **akpan** sought empathy from family members but not necessarily validation of their symptoms. Prayer followed this stage for all informants and was present between each successive step in the decision-making process, as **Annang** informants believed there was always hope for religious intervention in their health needs, be this intervention from Christian, Animistic, or native dieties.

For those individuals whose family had no significant limitations on finances, the western health care system was accessed immediately. This also included the priest, whose utilization of western health care technology was sanctioned by his bishop. Where financial concerns were barriers to the western health care system, another option was selected. In four cases, informants stated they would speak to the **Idiong** man who consults the oracle and offers a diagnosis of the health problem. Payment for services is made prior to seeing the **Idiong** man, and can be made in the form of produce, and/or alcoholic beverages. With a diagnosis, the **Idiong** man recommends a treatment and the patient and their family accesses either

an herbalist in the community, a trades-person in the village market, or a chemist.

In five cases, the informants stated that if no cure was achieved, they would cease looking and pray. This, they stated, was because they had made individual decisions regarding their own worth to the family and the limits to which they would expect family resources to be applied to themselves. This sentiment was common for older women, widowers, young children, and the disabled. Four individuals stated they would go on to the western health care system and would find money "somewhere in the family...but it would be a last resort." One participant had already undertaken this decision-making process with her husband, with no alterations in his level of functioning. Together they had made the decision that they would no longer request their family's assistance, nor take it if offered. Four informants regularly attended prayer houses and had seen faith healers, but had not sought further assistance for their health concern from their own family.

CHAPTER V

Discussion of Findings

Decision-Making for the Annang

The case studies and semi-structured interviews used for this research themselves, did not yield indepth information on the health care and/or ethical decision-making processes of the **Annang**. They did, however, serve as an entree into participant observations which allowed the researcher to compare and contrast what the **Annang** say and what they do in family decision-making matters. The limited variability of the responses can perhaps offer a number of insights. First, the answers may reflect the desired outcome each individual had for the situations. In other words, respondents answers gave their "ideal" outcome for each situation, but not necessarily the way in which decisions would actually be arrived at in their community. Second, the answers may represent what informants believed the researcher wanted to hear. This would be an example of: researcher bias, the courtesy effect, or saving face for the foreigner, all well documented forms of bias in research literature. Third, the responses may represent the true way in which decision-making occurs amongst the **Annang**. This

option however, does not hold true when compared to participant observation data collected during the same field study. Fourth, the responses may represent a combination of the previous three explanations, suggesting the need for more research in the area of ethical decision-making, to validate the data collected in this study.

Although descriptive statistics are one means by which health care utilization by the **Annang** in **Abak** Local Government Area facilities could have been documented, difficulties existed in verifying the numbers of individuals utilizing traditional and emerging health care systems. Furthermore, such documentation was of limited value in examining ways in which family decisions pertaining to health care were reached by the **Annang**. This point is best illustrated by the majority of study informants who in discussing the case studies, suggested ways in which health care needs "ought" to be met, yet in reality seldom did so as such for themselves. The gap between "ideal" and "real" methods of health care decision-making was made evident. Therefore an awareness of factors involved in the family decision-making process which ultimately impedes or enhances the opportunities for an **Annang**

individual to access the various health care systems available was deemed appropriate.

Health Care Decision-Making Amongst the Annang

In 1976, Brink believed there had been "little change in traditional patterns of behavior [amongst the **Annang**] as a result of either British colonial rule or federal government rule" (p.4). Areas in which change was denoted between Brink's field study and the present one, however, included: formal education systems, ruling political parties, the rising influence of all forms of religion, economics, western health care delivery systems, and the incorporation of various levels of technology in daily life. In contrast, core societal structures, beliefs and values such as the extended family system, polygamy, kinship allegiance, traditional judicial systems, division of labour, status seeking and demonstrative behaviours, and societal hierarchies related to age, sex, experience and lineage remained virtually untouched.

The **Annang** decision-making process in this study began with an individual who, after some period of deliberation, self-treatment, and in

most cases, prayer, made the decision they were unwell and sought validation from other family members. This led to a request for assistance from immediate and extended family members for health care services (Brink, 1976). In the author's experience, the illness was usually associated with some degree of functional impairment such as, difficulty preparing food due to shortness of breath, or inability to weed the garden because of pain in the lower back. Illness was only a "given" once another member of the family had validated the individual's claim. The validation was also dependent upon the experience other family member's had in identifying the specific type of functional impairment. This meant a witnessing of the signs and symptoms related to the functional loss was required, and this most often was the responsibility of the family **akpan** or his "informed" designate. A verifiable disruption in the individual's ability to function normally and fulfill one's role was then of significance to others and not merely self. At this point the illness had an actual or potential impact on the

entire family's productivity, and/or well-being and therefore deserving of attention.

Once signs and symptoms were validated, the **Annang** family had two options. First, they could "wait and see" if the illness cleared on its own, or second, the family could decide the illness required some degree of intervention (Brink, 1976). Conditions in which families were observed to not seek immediate intervention included: infant fever, diarrhea, arthritic conditions, some cardiovascular disorders, respiratory complications, non-life threatening trauma, dizziness, headaches, malarial symptoms, superficial cuts, disruptions in eating patterns, parasitic, bacterial and amoebic infestations. In addition, infectious diseases and other conditions not requiring emergent care and/or for which symptoms disrupting normal functioning did not persist over time (impeding the individual's ability to carry out incumbent role responsibilities), were not observed to receive interventions.

Annang villagers demonstrated that upon validation of the family member's need for health

intervention, "individual and family worth" were evaluated. Due to the harsh economic times, family resources were not spent without consideration of the return for investment. Factors evaluated included:

1) physical productivity (past, present, future)
2) allegiance to family (past, present)
3) prior requests for resources
4) return for past investments
5) gender
6) marital status
7) age
8) "goodness" of life lived (referring to issues of kindness, obedience, allegiance to family, veracity, contributions to family well-being, child-bearing and rearing capabilities)
9) family's access to disposable income
10) family's perception of critical nature of illness
11) degree of individual's observable impairment
12) social status

These factors were discussed both in the presence and absence of the individual requiring financial assistance, and delivery of the decision for or against intervention, was delivered by a senior male.

In the absence of available economic resources, a number of the health care options suddenly dissipated for **Annang** villagers. What at one time may have been an "ideal" tripartite

system of health care services, now represented largely unattainable, inaccessible and underutilized community resources. Increasingly, families were observed to take loved ones to missions, faith healers, churches and prayer houses, where "miracle" cures were paid for in the form of offerings and/or gifts, but usually after a health status improvement had occurred. In this way, if productivity of the individual was enhanced, payment could be made later, after the patient and/or family had time to raise the necessary funds. Also, if renewed strength was observed at home, often the family payment would exceeded what was required, in order to "give thanks for the healing." This form of deferred payment varied significantly from the western, and traditional health care systems, where payment in one form or another, was usually required prior to the initiation of treatment. Alternatively, if symptoms did not subside, the "healer" could:

1) suggest the cure was unsuccessful due to a "lack of faith on the part of the patient and/or family"
2) recommend a lengthier healing spiritual healing process
3) have an emergent situation come up, whereby the patient would be moved to a hospital where services were paid by the family, members of the congregation, the health system, or the clanhead,
4) have a patient die, in which case the individual would be used as an example of a non-believer who "offered too little too late to the lord."

The value in such a system was that the spiritual healer never had to assume responsibility for disability, pain or death. The responsibility for the health crisis remained that of the family. Additionally, when health concerns were not resolved in a favourable manner, meaning could be ascribed within a religious context, freeing the villagers of responsibility for issues believed to be **Abasi's** or God's will. This was often represented in the villagers' comment "it is not for us to know - it was meant to be."

For those families, deciding to access other areas of the health care system, the family was seen to make the decision pertaining to which system and healer would receive the family member. This stage, had two phases in which availability (distance, transportation and home versus office

visits) and previous experience (eyewitness and past experience) with the healer were considered.

During this study the western health care and alternative health systems were not readily utilized by **Annang** villagers due primarily to issues of accessibility. Patients were expected to visit western and alternative health care facilities in person, requiring transportation for self and other family members at a considerable expense. Such transportation costs were seen to be barriers to the two health systems, located in well populated settings, as opposed to rural areas where the majority of villagers lived. This led families to examine more often the use of traditional health care services and faith healers who were geographically closer, and often having healers willing to travel to the client. Lack of availability did not appear to be a major concern, as many facilities in the western and emerging systems were observed to be far below optimal patient capacity. Accessibility, affordability, credibility, and modus operandi were, however, seen to be problems.

Having determined the accessibility and availability of the available systems, decision-making was then based upon previous experiences with individuals working in these areas or hearsay evidence of the practitioner's skills (Brink, 1976). This gave the family an idea of the practitioner's skill with the particular illness, the fees that may be expected and where the specific person could be located. Much of this issue reflects the family's desire to get their "monies worth" out of the treatment, to be accessing someone with a history of successful treatment for the illness, and generally to be utilizing someone known to be accountable for their abilities.

Once deciding upon and accessing the appropriate health care system, the family and healer decided on a differential diagnosis and course of treatment (Brink, 1976). During this phase of the decision-making process, although the family deferred to the healer's therapeutic knowledge and technical abilities, at no time did they surrender their responsibilities for the patient's overall well-being. Instead, they

remained active participants in the therapeutic regimes, reserving their right to stop treatment at any time they believed their family member's well-being was jeopardized. This meant ensuring the family member's status was respected at all times, that treatment's were in keeping with all societal considerations, treatments remained beneficial for the patient, and the overall cost of the intervention was acceptable for the family. Often these considerations were evaluated based upon the observations of one family member who remained with the client (when possible) throughout the course of treatment, offering familial support to the patient and a strong family voice in the health care system's processing of the patient. At any time during this phase, when questions came up pertaining to one or more of these areas, the family could remove the patient back to the family compound and to the beginning of the decision making process once again if need be.

The last phase of the decision making process was deciding: 1) when the patient was well enough to return to the family compound; 2) whether all

treatment conditions had been met; and 3) whether the individual was capable of returning to a state of normal family functioning. As Brink has stated, the patient often recovers, because the healer "told the family the patient would be well at the end of the treatment regime...and the family expects the patient to be well at that time" (1976, p.12). This means that whether or not the family member returned with the same symptoms they were expected to resume their normal roles within the family. The patient was "on the road to feeling well" having received all the benefits of treatment and now expected to resume normal well-being. In these instances the responsibility was that of the patient to act as though they were recovering and eventually recovered. If the patient demonstrated no improvements under the healer's care, the family then decided: if the healer had mislead them in their hopes for a cure for their loved one, whether further treatment would be pursued, if use of another healer would be preferred, or if they would merely have to accept the situation - a family member with limited functional abilities, the loss of valuable

family resources on the unsuccessful treatment, and the loss of faith in this form of treatment for similar concerns in the future.

The Annang "Ethic of Family"

Core societal structures, values and beliefs are presumed to be significant variables which influence health care decision-making. As individual, family and village health outcomes are dependent upon such variables, discussions of **Annang** decision-making must be accompanied by a description of the structure and function of the family unit, for it is within this context that decision-making occurs. Furthermore, the roles one plays within the family unit, and the value and status of each member, contributes significantly to health care decision-making and the allocation of family resources to meet individual needs.

Numerous authors have illustrated the efficiency, profound beauty and stability of the "clan" system of social structuring in Africa and specifically among the Annang (Amadi, 1982; Apostel, 1981; Atuado, 1985; Aeanbor, 1982; Ekandem, 1957; Essien, 1980; Maclean, 1971; Messenger, 1970, 1959; Noah, N.D.; Obarisiagbon,

1988; Uchendu, 1965; Udo, 1983a, 1983b; Achebe, 1958). The uncompromising respect for the clan and one's immediate family, as was the case in traditional rural Annang society, made other forms of colonial government or social ordering quite unnecessary. With the arrival of foreign powers, the traditional system showed outward signs of weakening when confronted by so called "civilizing" agents from Europe. Traditional values however, seem to have so thoroughly permeated this society that outside forms of authoritarianism were inadequate in comparison to the society's own ability for self-regulation.

Annang values identified and documented through participant observation in this study offer present-day insights for a community which has maintained cultural integrity in the face of global societal changes. Without question, family (past, present and future) remains the focal point for individuals, families and communities. In addition, values such as utilitarianism, productivity (as it relates to lineage), respect for formal and informal social hierarchies, male issue and specifically "getting **akpan**,"

responsibility to extended family (including second burials), respect for social taboos, commitment to family decision-making processes, faith, and social worth were found to form the foundation of **Annang** society.

Maquet (1972), Achebe (1964, 1960, 1958) and Rotimi (1971) have descriptively emphasized the importance of the family network in all aspects of individual, clan, tribal and African life today. In this research, the family was found to be the core of the society and self, directing all aspects of life. This process occurred while: finding one's place amongst kin, depending on lineage for survival, playing one's role in the lineage, living out the lives of ancestors, being in harmony with one's existing reality, respecting the forces which shape one's life, accepting the responsibilities of all life stages, ensuring the continuation of the lineage, living and participating in the community network, identifying oneself through others and succeeding through heredity. In this way the **Annang** child is born without culture, but becomes Annang. The human and physical environment that gradually reveals itself to him/her and that gradually broadens around them "is different from the

existential environment of the American or European child" (Maquet, 1972; p.55). Cultural reproduction, takes place through the processes of adaptation and diffusion, thereby creating successive generations of individuals enacting centuries old values, beliefs and practices.

Proverbs used by informants in the study effectively illustrate the extreme importance of the family unit for the **Annang** and Africans in general (see Appendix J). Examples of such include:

1. **Eto idaha ikpon ikaba akai**
   (A tree cannot stand alone and form a forest).

2. He that has a brother must hold him to his heart, for a kinsman cannot be bought in the market, neither is a brother bought with money. He who has brothers has more than riches can buy.

3. **Ada ke urun**
   (Are you so small).

4. "Wherever something stands - another thing stands beside it. You see this thing called blood. There is nothing like it. That is why when you plant a yam it produces another yam, and if you plant an orange it bears oranges. I have seen many things in my life but I have never seen a banana tree yield a coco-yam...You see a man may go to England, become a lawyer or a doctor, but it does not change his blood. It is like a bird that flies off the earth and lands on an ant-hill. It is still on the ground" (Achebe, 1960, p.145).

5. "The Annang believe that the unity and progress of the family is in the hands of those who control the entire family...if the extended family system is left to decay, the life of the mother tree will perish and the identity and the origin of the family...forgotten" (Udo, 1983a, p.60).

There are benefits and limitations to the extended family system which have been described in **Annang** literature as well as by participants in this study. The benefits of such a system are: 1) individuals who can be nurtured by the group in difficult times; 2) social and economic assistance obtainable through the extended family in an area in which social welfare is not yet a reality; 3) responsibility gradually offered following long periods of apprenticeship; 4) an individual who can share responsibility for personal failings with group members rather than shouldering total responsibility for oneself; 5) reciprocity in kind, for those members who maintain allegiance to the family - at all costs; and 6) the awareness that the family's responsibility to it's members never ceases until the time of the second burial.

Limitations of the extended **Annang family** system include: 1) the excessive financial burden imposed upon family members, and specifically **akpan** (the senior son); 2) lack of personal autonomy in the decision-

making process; 3) the male domination of most decision-making processes; 4) the potential for nepotism and tribalism (Amadi, 1982); and 5) decision-making behavior reflective of senior/junior, and male/female role relationships. Each of these points are believed to have significant effects decision-making regarding resource allocation for **Annang** family members and are therefore believed to be intrinsically linked to health status of the community.

Annang Worldview

During this study, the **Annang** worldview and their beliefs about health and healing were reflective of religiosity and spirituality. This point is illustrated by the large number of study participants who attribute illness and/or disease causation to imbalances between good and evil spirits or an "angering of the gods." Correspondingly, disease and/or illness was more often treated through the various religious institutions in the **Abak** area rather than by native healers, chemists, primary health care workers or at health facilities.

The **Annang** spiritual perspective is perhaps best described in the book "Things Fall Apart" by Achebe (1958). In this book it is suggested that the arrival of outside religions in places like Nigeria succeeded

mainly in destroying traditional socio-cultural values and social mechanisms without replacing them with social structures that were in any was superior, and in most cases decidedly inferior in those specific settings. In some instances zealous missionaries were known to argue with tribal elders that traditional gods, beliefs, and values were abominations and that the only real religion was Christianity with its single god who created the universe and all that exists in it. The elders point out that their religion has a similar creator **"Abasi"** the rest of the minor gods mere agents for the all-powerful deity - much the same as missionaries who are agents for their God. In many ways, **Annang** informants feel their traditional societal beliefs and family structures received little respect from colonial and religious authorities who entered their communities and outlawed many of their ways calling them "devilish and evil." As Akpaidiok states:

> It wasn't that people here didn't know the differences between right and wrong - good and bad. Rather, it was the way that we went about enforcing the right and wrong deeds in our community. It wasn't merely bringing a conscience to the people here and also being given a belief in a higher God - because we had that before the missionaries came...everybody believed in God there had been God all the time and that is why I liken the **Annang** [religious] traditions to Christianity. We believe in the God-head - **Abasi** - we believe in the trinitarian doctrine (the holy trinity)...we talk about three God-heads in one. In Christianity it is supposed to be a mystery and cannot be explained. In **Annang** it is very simple. The Annang believe there are three Godheads: 1) God-head of the forebearers - **Ajejen**, 2) God-head of the race - **Iman,** and 3) God-head of the off-spring - pertaining to where the mother comes from - **Ukot. Ajejen**, **Ukot**, and **Iman**...these are the three pillars that a man leans on and lives with. He lives with his people - the same race, he lives with people from whom he is married, and he lives with the people to whom you belong, that is the family alliance. Outside of that, there is no other person, everybody who comes along belongs to the same group (1989).

The similarities and/or contradictions between Christian and traditional religious approaches have yet to be reconciled in the eyes of villagers. For this reason perhaps, they pursue both Christian and traditional religious veins. One thing remains true however, for individuals supporting either domain, that being the individual's attempt to explain "anomie" through the use of deities.

The present revival of extrinsically motivated participation by villagers in all forms of religious

life may in part be explained by Campbell's 1959 view of religiosity. Campbell believes there is a necessary transformation of religion at the point in history when man shifts the focus of his society. For example when man shifts from hunting and gathering societies to agricultural societies, transformations require that social mores based on individuals and their immediate kin be switched to new social values based on group ethics. Shamans of hunting societies are therefore replaced by more institutionalized forms of worshipping, and later temples and other components of new religious forms.

Campbell (1959) speaks of the new "Age of Anxiety" and speculates that the most recent shift from agricultural society to newly industrializing societies has not been accompanied by a corresponding evolution of relevant myths or gods for the present turbulent times. In this view, attempts to revitalize traditional mythologies and incorporate Christian doctrine and secularism in traditional religious forms, appear to be the way in which **Annang** villagers are enabled to explain their "anomie." Inadequacies of the various approaches seem to be that traditional mythologies may be a doomed attempt to cling to answers that were

sufficient only in a distant past, and latter approaches producing the doubt and anxiety that comes with having to develop your own answers to overwhelming issues. Correspondingly, efforts to produce any coherent mythology in the present time of economic upheaval are made much more difficult by the fact that the **Annang** are becoming increasingly educated and therefore much more difficult to pacify and be dictated to by contradictory religious dogma.

Faith healers, historically and at the present time exert a powerful influence over **Annang** village life. This influence may exist because faith healers ground their curative powers in religiosity, the foundation of all **Annang** life, a perspective often absent in western health systems which attribute their healing abilities to bio-medical science. As Umoren (1990) states "The **Annang** worldview is a religious one. Religion explains the how and why of things, provides psychological reinforcement in crises, judges and evaluates and finally systematizes as well as orders perceptions into a design...for the **Annang** to live is to live in a religious milieu" (p.5). This **Annang** insight may explain why systems which

incorporate a particularly "religious world view" appealed moreso to villagers still ascribing to these beliefs during this study.

Ethical Decision-Making Amongst the Annang

Although claims that a poor study instrument and/or researcher bias may explain why respondents offered "ideal" answers of equality and justice for all in the case studies, the researcher does not hold this to be true. On more than one occasion, the researcher was confronted by youngsters, adolescents, young adults, women who were fecund and women who were not, as well as the disabled who talked about their "wish for a society in which all individuals were equal." This is illustrated in the statements of a group of informants near the end of the study:

> We long for an **Annang** world where all members know the same degree of happiness and comfort. Now many of us know fear and pain. We live hard lives. Some of this is the result of economics but much is the result of our culture and it's social structure...When we were young, we believed that no one could have a better life than an **Annang**. Having lived our lives, we now know that is not true. In the future, we wish not to be born **Annang**. In the next life, let us be born somewhere else where respect and goodness, equality, and kindness are the rule. Let us have food and shelter and security.

In this study, the **Annang** did not see, or describe, themselves as making decisions of an ethical nature or within an ethical framework. This conclusion was reached by qualitatively examining the means by which they reached family decisions. Although not all examples described through the process of participant observation in this study reflect health situations, it is believed that insight has been gained as to the rationale underlying **Annang** family decision-making in general.

In examining the Annang within their own cultural milieu, principles which form the base of ethical decision-making in western health care systems were seen in a new light. Unique to the **Annang** is that ethical principles which commonly guide western ethical decision-making models were superceded in all cases by an "**ethic of family**." Individuals were acknowledged, but all forms of individualism were discouraged. Where autonomous action was suggested, it occurred only if a direct and immediate benefit for the family could be perceived. Justice was a principle which guided family decisions, but only so far as it did not inhibit the family's ability to secure it's own best interests.

Decisions related to goodness and doing no harm prevailed so long as the family's status was not impinged upon. Veracity existed where there was no perceived threat to the family's integrity. If the family's security was challenged in any way, then alteration of the truth became a tolerable solution. Fidelity to family and lineage was the ultimate good a family member could offer to the community. Fidelity was often measured in an individual's productive capabilities which to the **Annang** is faithfulness observed. For men, productivity meant securing an income which could support and maintain the family as a unit. For a woman, productivity was measured in physical capabilities - including those of labour and child-bearing and child-rearing. Male issue was the ultimate measure of a woman's productive capacity for the family and was rewarded with status and varying forms of security as well as individual freedoms.

The criteria which defined ethical decision-making for this study were met by the **Annang**. They were found in their family based decision-making processes to: 1) be committed to good; 2) gather relevant facts related to the matter; 3) use clarity of thought in the evaluation of their

options; and 4) use a basic set of moral principles in deciding their course of action. Arguably however, their commitment to good, relevant facts, exploration of options and moral principles are primarily applied within the context of the family unit and culture. Their concerns were not so much with "human rights" as "family and **Annang** rights" and the implications of such a philosophy for the field of bio-ethics requires further research and assessment.

CHAPTER VI

Summary of Findings

The Annang of Nigeria

As Meleis and Jonsen suggest "it is necessary from both an ethical and practical viewpoint, to comprehend the values and beliefs of patients from cultures quite different from our own" (1983, p.889). This study represents a beginning contribution to the understanding of indigenous approaches to decision-making as it relates to bio-ethics and the allocation of health care resources. The **Annang** "experience" explored in this study strongly suggests that decision-making processes are intricately related to, and synergistically affected by, factors such as: literacy, the status of women, history, available health care systems, religion, traditional beliefs, values and practices, socio-economic status, Nigerian politics and policies, and the world capitalist system. Furthermore, the **Annang** decision-making processes remain the domain of the extended family system, significantly affecting the allocation of family resources for health issues as well as the mix and numbers of patients

seen in the various health care systems available to this population.

Health care decision-making models are one way in which health care professionals may understand the nature of the decision-making processes which occur within variant cultural groups. Brink's model (1976), revisited in this study, allows some understanding of the context in which **Annang** families make health care decision thereby affecting the health status, number and mix of clients seen in local and regional health care facilities. When utilized more effectively, such a model could potentially influence the ways in which health care workers choose to access **Annang** clients, implement programs and create a more equitable health care delivery systems for this cultural group. Such improvements can only contribute to a gradual improvement in the general health care status of the **Annang** and of Nigeria's populace. The model also offers outsiders an appreciation of the ongoing responsibility assumed by the **Annang** family unit for the rights and well-being of family members who become patients within one of the health care systems. Areas requiring

greater exploration in relation to this issue remain. These include: 1) the recognition and inclusion of religion in health care delivery and improvements; 2) further research on native conceptions of illness causation and cure; 3) factors influencing individual worth and the subsequent decisions regarding allocation of scarce health care resources; and 4) cultural symptomology of the **Annang**.

The findings of this study appear to be threefold. First, smaller numbers of the **Annang** are accessing the formal and/or informal health care systems which appear economically out of reach during the present Nigerian Structural Readjustment Program. Second, the innumerable churches, missions and prayer houses in the **Abak** local government area are receiving ever increasing numbers of the **Annang**, who, in attempts to meet health care needs during periods of "anomie," are seeking what are considered to be less financially taxing, spiritual cures. Third, the extended family system remains the most viable means of meeting the health care needs of family members. In the absence of reliable social welfare

programs, which allow individuals to meet health needs in times of economic hardship, dependence on and allegiance to family units, will prevail, in the face of other social development schemes. In this way, the **"ethic of family"** becomes more firmly entrenched in the **Annang** family "ethos".

The Annang "Ethic of Family" Seen in Nigerian Context

Although recent African studies have emphasized the preeminent influence of education, particularly the level of women's education, in the reduction of mortality and fertility rates and an improvement in family health status, Nigeria represents an exception to these assertions. An increase in the per capita income in the absence of other socio-economic and political improvements has had little effect on changes in overall mortality for the nation. Furthermore, a minimal redistribution of income on expenditures such as education and preventive health measures resulting from the Structural Adjustment Program, appears to have increased rather than decreased reported levels of fertility.

Many of the previous civilian government's health care and educational policies were rescinded by Babangida in 1985, with claims that an "excessive proportion of Nigeria's resources had been devoted to health and education at the expense of other development goals" (Kuran, 1989 p.1486). Policies supporting rapid expansion of health care, educational facilities and personnel have been reversed. In 1981 at the height of the educational expansion program, government contributions were approximately $3,152,687 which was 6 percent of the gross national budget. By 1984 this figure had dropped to $814,470 or 1.3 percent of the gross national budget (Zartman, 1983). Subsequent figures on educational spending to date have been difficult to obtain.

The impact of such policy reversals has been telling for Nigerians and the **Annang** in particular. Oni (1985) has revealed that in a study population of 913 married women, in the active childbearing age, demand for children, despite educational level remains high: 4.9 children for those with post-secondary education and 6.6 for those with no education. Supply of

children in this study was also seen to be high and is supported by a total Nigerian fertility rate of 7.1 percent in 1985 (Grant, 1987). Infant mortality rates however, have proven to be higher for children of polygamous marriages than those of monogamous marriages (Akande, 1987; Oni, 1985). This is thought to be related to the relationship between polygamously married women who "are more likely to be traditional, to be poorer, to live in a poorer area, to be less-well educated, to do work that requires no education and to be married to a man with similar characteristics (Akande, 1987, p.407).

Such statistics create uncertainty and pursuance of ways in which health care innovations may more adequately and equitably reach the majority of Nigeria's population are required. Commitments to primary health care, promises of a redistribution of health care funding and resources by the Minister of Health, and the provision of appropriate technologies may offer hope for the system, but do nothing to account for the individuals who must make their decisions about accessing such services given the context in

which they exist. Despite the Nigerian government's commitment to western health care technologies of 2.4 percent of the national budget, the majority of citizens rely upon self-care technologies, the extended family, religious groups and native healers for health care needs. As a result, health for the majority of the study sample, the **Annang**, remains a social ideal, seldom a reality.

It is no mistake in the face of such national factors that the **Annang** still seek assistance primarily for acute health problems. Meagre family resources provide for basic necessities and emergent health needs, seldom those of health promotion and disease prevention promoted by primary health care workers. **Annang** families presently, as in the past, work within their environment to secure food sources, shelter and nutrition and to ensure the survival of the clan through populous families and extended family systems. To their credit, the **Annang** provide a stable community in which gradual improvements are part of their cultural heritage rather than a policy of some national or foreign influence. This

is seen in one small example, the traditional **Annang** sanitation days (whereby personal and communal living spaces are cleaned), which have for centuries been part of their daily life and most recently enshrined in government health care policies (personal communication, E. Sade, 1989).

If the improvement of health status for all is considered a priority for the **Annang** and if social development is more than just an espoused indigenization goal, then structural and functional changes appear to be warranted for many of the previously mentioned factors. Perhaps the developmental task which faces the many is not the manipulation of human behavior to suit the needs of out-moded and oppressive institutional structures; instead, it is to change those institutional structures to suit contemporary human needs.

Cultural Pluralism and Ethical Decision-Making

Cultural pluralism involves "...a range of structural and political relationships within a society characterized by cultural diversity, some minimal level of interaction between the diverse groups, relative equality of opportunity between

groups, and a perceived value for the continuance of diversity within society" (Appleton, 1983, p.29). While cultural pluralism is supported by health and government officials in many nations, and legislated by federal and provincial multiculturalism policies in Canada, little has been done to actualize this goal in the realm of ethical decision-making in health care domains.

What is unique about bio-ethical dilemmas arising in pluralistic societies, are the experts from various disciplines who attempt to address such issues using decision-making models and legal systems which reflect western philosophic and Judeo-Christian traditions (Engelhardt, 1992, 1989; Cooper, 1990; Veatch, 1989; Habgood, 1986; Mason, 1985; Minami, 1985). Although health and illness are known to occur within a cultural context, the implications of such in ethical decision-making remains in the exploratory stages in nursing and related health care disciplines.

Culture is defined as "the totality of knowledge and behaviour, ideas and objects, that constitutes the common heritage of a society...the only things it does not create are those

characteristics that depend either on universal human nature or on our own individuality (Maquet, 1972, p.4). If, one assumes that humans do have a nature, constant throughout time, culture and space, there becomes a need to describe that which is, in order to contemplate that which ought to be. Conversely, if one believes humans do not have a common nature, and being is relative and/or culture bound, then the foundations upon which ethical decision-making are based become suspect (Simmons and Hughes, 1985). Inevitably the position one assumes in such debates enables individuals, families and societies to: prescribe "rights to the things we need in order to discharge our moral obligations" (Adler, 1985, p.127), and/or direct us to become non-partisan in debates centering on "goodness," "evil," "right," "wrong," what "ought" or "ought not" to be.

Ethics is the branch of moral philosophy, referring to knowledge of right and wrong, good and evil, and what ought or ought not to be done (Veatch, 1989; 1982; Storch, 1982). Ethics "does not attempt to supply solutions for dilemmas, but... undertakes to provide a rational framework

for comprehending the complexities of moral judgement" (Smith, 1980, p. 453).

The discipline of ethics is composed of two distinct, yet inter-related branches of human knowledge. The first branch of knowledge, non-normative ethics, is speculative or descriptive knowledge, that which is known about reality (Bodunrin, 1985; Adler, 1985). From that which is known, we are able to contemplate what ought or ought not to be. The second branch of knowledge required to make ethical decisions serves to prescribe or suggest what norms ought to be and is referred to as prescriptive or normative ethics. When combined, the two branches of knowledge suggest that ethics must be relevant to be authentic and to be authentic, the incumbent information must arise out of issues thrown up by a full range of experiences of life itself, not just events, or the interpretation of such, as understood by individuals from a limited number of dominant cultural groups.

Engelhardt (1989) states that "Pluralism and relativism are indisputable socio-cultural realities" (p.33) yet the role of cultural

pluralism in ethical decision-making remains a source of contention for moral philosophers (Engelhardt, 1992; Cooper, 1990; Brink, 1989c; Veatch, 1989; Blocker, 1987; Mason, 1985; Adler, 1985; Beauchamp and Childress, 1983). Concepts such as individualism, pluralism, cultural relativism and normative relativism blur, but do not obliterate, the value variant cultural information may have for moral philosophy. Traditionally, the role cultural pluralism has played in moral philosophy has been limited, due to the relative homogeneity of the communities for which ethical decision were made. With the legal rights now afforded minorities and a growing trend to greater cultural contact through the media, travel and technology, the debate must again surfaced. The central question being: Is moral philosophy subjective and relative, or objective and absolute? Furthermore, what implications does one position or the other have for the ethical decision-making processes cross-culturally (Engelhardt, 1990, 1989; Veatch, 1989; Tranoy, 1988; Benatar, 1988; Blocker, 1987; Mason, 1985;

Feldman, 1985; Laidlaw, 1988; Lindbeck, 1984; Minami, 1985; Rachels, 1980).

Acknowledging the above stated positions, how then is one to proceed to incorporate cultural pluralism into each of the two branches of moral philosophy? First, there must be more research in the descriptive realm of knowledge, with greater attempts made to document what is known cross-culturally about the human condition. The present study is an attempt to document the decision-making processes of one culturally variant group, the **Annang** of southeastern Nigeria, for whom little is known in relation to ethics. Second, by expanding knowledge about what is known cross-culturally and not just in western traditions, the potential exists to gain new knowledge and understanding about what ought to be for humans. In this light, the relevance the "**Annang** ethic of family" for ethical decision-making in western societies must be explored. As the heterogeneity of populations increases, the necessity for teleologic ("grounded in a comprehensive purpose of 'telos' that is objective and normative, but that forever transcends concrete institutional

embodiment or ideological formulation" Phenix, 1969, p.4) ethical decision-making models combined with legal imperatives arising from challenges to new multicultural policies must now be realized.

Delimitations of the Study

When analyzing a complex issue, one invariably becomes suspect of particularistic approaches. This study of ethical-decision-making amongst the **Annang** of Nigeria is no exception. Although descriptive/ ethnographic methodologies known for yielding rich information were utilized, an understanding of the totality within which **Annang** decisions were made in this study may inadvertently have been lost.

The design utilized for the study in itself carries inherent limitations. Due to the descriptive nature of the study, information generated may only apply to other **Annang** villagers who: (1) are in a similar stage of the acculturative process; and (2) come from similar geographic areas, socio-economic classes, educational levels, and religious backgrounds. As a result of being unable to manipulate variables

such as the ones listed, the researcher has attempted not to make causal inferences.

While it was desirable to conduct this study in a natural setting, there may have been bias introduced to participant responses by: 1) village elders and family members who may have influenced responses given by study participants; 2) a tendency on the part of participants to informally share ideas regarding the study with other village members prior to interviews; 3) environmental distractions that may have influenced responses during the interviews: 4) the limited time the researcher had in order to carry out the research; 5) a desire by study informant to respond in a fashion which was perceived to be acceptable by the researcher; and 6) the investigator's own inexperience at conducting research in field settings. As there could be no control over the accuracy of the respondent's self-reporting, the researcher has accepted responses as truthful.

Although measures were taken to provide anonymity, and ensure respect of cultural values and practices, the possibility exists that the researcher's presence itself altered responses and

observations of participants. The effects of such are acknowledged but cannot be measured. The researcher was also aware of a number of other variables known to affect the collection of data in qualitative research projects. One such factor is the well known courtesy effect, whereby individuals make statements, be they true or untrue, simply to avoid being rude to the individual asking the questions (Kulig, 1987; Field and Morse, 1985; Noah, [no date]). Another factor, the patrilocal, patrilineal, polygamous and hierarchical social structure observed in **Annang** villages, may have prevented certain individuals from responding independently to questions. For these reasons and others, Stage I served as an opportunity to identify major areas of weakness in the study design, after which revisions were made prior to the initiation of Stages II and III.

An additional limitation to the study is that much of the available published information on the **Annang** of Southeastern Nigeria, represents views that have been formulated on historical, descriptive and in some cases less than reliable

sources (Balabkins, 1982; Noah [no date]). In numerous articles, the **Annang** are referred to as the **Ibo** or **Ibibio**, cultural groups living in close proximity to the **Annang**, but considered by the **Annang** themselves to be distinctly different tribes. In addition, a large percentage of the information on the **Annang** has been documented by foreigners and/or the compradore elite of Nigeria, referring to those individuals educated and trained in the colonial tradition who seek to blend western and indigenous cultures for the purposes of nationalization (Chirot, 1977). Hence, a number of sources used for this study may not represent the rich social, political, religious and cultural heritage for the majority of the **Annang** of **Afaha Obong**.

As is true of most developing nations, historically and at the present time, foreign approaches tend to dominate many aspects of the research process (King, 1983). Although this study represents one of the few examinations of decision-making and the allocation of health care resources by the **Annang**, it is still one of a series of "etic" studies for this population. In

order to avoid purely "etic" interpretations, the researcher attempted to ascertain the "insider's" point of view by eliciting the rationale for decisions reached through additional field observations and by locating archival materials previously unavailable on the subject. The fact however remains, the work was investigated by, assigned meaning to, and written for the **Annang**, not by them.

A more recent yet related concern is that Nigeria's population statistics are thought to be some of the most inaccurate amongst black African nations today (Balabkins, 1982: Zartman, 1983). Although the demographic data is not an end in itself, it is believed to be useful as a means for assessing, planning, describing, comparing, monitoring, researching, and evaluating various social systems. The last official Nigerian census was conducted in 1963, and current demographic indices represent statistical abstractions thought to best approximate the nation's current conditions. As published demographic information is one method by which a nation's overall progress may be critically analyzed and/or substantiated

both nationally and internationally, the existing data base available for Nigeria by enlarge has inhibited any such a process for this study (Balabkins, 1982). However, as Zartman (1983) suggests:

> ...interesting as it would be to have reliable data on these matters, the more interesting questions concern the way in which change is felt and perceived. For ultimately, the stimulation and continuation of improvement depends on whether expectations are aroused and satisfied, and in relation to which reference point - one's own past, others' present, or the future (p.12).

These points highlight a few of the difficulties inherent in this and other attempts to examine cross-cultural issues, irrespective of training or intent. As a result, caution has been used in the interpretation of data related to health care decision-making amongst the **Annang**.

Recommendations for Research

Veatch has stated: "...in future care delivery systems targeted to ethnic minorities, it will be necessary to recruit caregivers and administrators who are at least sensitive to their values and beliefs...the current paradigm of medicine will no longer exist" (Banning, 1992, p.11). This researcher suggests it is time to go

beyond "sensitivity" to the values and beliefs of ethnic minorities in dominant cultural environs. It is time to acknowledge there are different ways of achieving the same end, and time to explore what such variations offer western health care and fields such as bio-ethics.

Much of the cross-cultural literature reviewed for this study has discussed the need to tolerate cultural variation in ethical decision-making - yet tolerance does not infer acceptance, incorporation, nor exploration of alternative world views. Tolerance inhibits the process of science and philosophy, by inhibiting the spirit of inquiry, learning, understanding, and change. As the Paramount Ruler of the **Annang**, Pastor E.A.U. Arthur Akpan has said "Change is not bad but inevitable." Seen in this context, the **"ethic of family"** which the **Annang** demonstrate in their decision-making processes, and presented in this work, should not be seen as a challenge to existing ethical decision-making models in western societies, but perhaps as one link in the inevitable chain of change.

As "the discipline of nursing is focused upon the person, the family, the community - humanity facing ill health - nurses are in the best position to discover ethical approaches to care" (Brink, 1989, p.519). A major debate in the field of ethics today is the supposed "play-off" or "play-between" justice versus relational/caring moral perspectives (Cooper, 1990; Davis, 1990; Gilligan, 1982). The **Annang "ethic of family"** may offer insights into the relational/caring perspective of moral reasoning as well as validating the role of cross-cultural variation in ethical decision-making. Such ascertations must however, be examined through the use of: greater field studies which document the decision-making processes of culturally variant groups; comparative studies of culturally dominant and variant ethical frameworks; philosophical research as to the way in which such information may be incorporated into the field of bio-ethics.

"Cross-cultural research in any discipline strengthens theory-building in that discipline. By comparing and contrasting aspects of different cultures, the investigator builds and tests

theories about those aspects selected in particular relevance to that discipline" (deChesnay, 1983, p.21). In the emerging discipline of nursing which is attempting to delineate it's role in the theoretical development and application of culturally relevant health care, there is a great need for systematic research. With the large influx of individuals from variant cultural groups now arriving in western communities, nurses have unique opportunities through ongoing research projects to: examine ethics in variant populations, assess needs and develop innovative strategies and decision-making models for use with the culturally diverse groups they serve.

As no one discipline has the ability to answer all aspects of this question, this study is seen as one of many research endeavors required to build and expand upon the theoretical foundation that presently exists for cross-cultural ethics and the impact this area of study may have for health care delivery. Greater research is required however, in the area of cross-cultural ethics in order that one may discover "universal"

foundations to the domain, culture bound components of the field, or some other permutation as yet relatively unexplored.

REFERENCES

Aamodt, A. (1982). Examining ethnography for nurse researchers. Western Journal of Nursing Research, 4(2), 209-221.

Achebe, C. (1958). Things fall apart. London: Heinemann Educational Books Ltd.

Achebe, C. (1960). No longer at ease. London: Heinemann Educational Books Ltd.

Achebe, C. (1964). Arrow of god. London: Heinemann Educational Books Ltd.

Adler, M.J. (1964). The conditions of philosophy: Its checkered past, its present disorder, and its future promise. New York: Delta.

Aeanbor, D. (1982). The healing process in African psychotherapy. American Journal of Psychotherapy, Vol. XXXVI, (2), 206-213.

Afigbo, A.E. (1971). Ibibio origin and migrations: A critique of methodology. Nigeria Magazine, 107 (9), 62-69.

Afigbo, A.E. (1977). Pre-colonial trade links between southeastern Nigeria and the Benue Valley. Journal of African Studies, 4 (1), 119-139.

Akande, B.E. (1987). Rural-urban comparison of female educational aspirations in south-western Nigeria. Comparative Education, 23 (1), 75-83.

Akpaidiok, S. (1989). Annang heritage. Unpublished Paper. Abak, Nigeria.

Amadi, E. (1982). Nigerian ethics. Ibadan: Heinemann Educational Books (Nigeria) Ltd.

Aminu, J. (1985). Teaming up for better health. Social Science and Medicine, 21 (12), 1349-1353.

Apostel, L. (1981). African philosophy: Myth or reality? Gent, Belgium: E. Story-Scientia.

Appleton, N. (1983). Cultural pluralism in education: Theoretical foundations. New York: Longman.

Ataudo, E.S. (1985). Traditional medicine and biopsychosocial fulfillment in African health. Social Science and Medicine, 21 (12), 1345-1347.

Balabkins, N. (1982). Indigenization and economic development: The Nigerian experience. New York: Contemporary Studies in Economic and Financial Analysis.

Banning, J.A. (1992). Post modern medicine. Canadian Nurse, 88 (4), 10-11.

Beauchamp, T.L. & Walters, L. (1982). Contemporary issues in bioethics, (2nd ed.). Belmont, CA: Wadsworth.

Beauchamp, T.L. & Childress, J.F. (1983). Principles of biomedical ethics. (2nd ed.). Oxford: Oxford University Press.

Benatar, S.R. (1988). Ethics, medicine and health in South Africa. Hastings Center Report, 18 (4), 1-8.

Benoliel, J.Q. (1984). Advancing nursing science: Qualitative approaches. Western Journal of Nursing Research, 6 (3), 1-8.

Blocker, G. (1987). African philosophy. African Philosophical Inquiry, 1 (1), pp.1-8.

Bodunrin, P.O. (1985). Philosophy in Africa: Trends and perspectives. Ibadan, Nigeria: University of Ife Press.

Brink, P.J. (1976). Decision making of the health care consumer: A Nigerian example. Communicating Nursing Research. Boulder, CO: Western Interstate Commission for Higher Education.

Brink, P.J. (1976). Transcultural nursing: A book of readings. Englewood Cliffs, NJ: Prentice Hall.

Brink, P.J. (1980). Systems analysis of health care delivery: The case of the natural triad. In Conceptual models for nursing practice, (2nd ed.). Norwald, CN: Appleton-Century-Crofts.

Brink, P.J. (1982). Traditional birth attendants among the Annang of Nigeria: Traditional practices and proposed programs. Social Science and Medicine: Medical Anthropology. Part B, 16 (21), 183-189.

Brink, P.J. (1984). Value orientations as an assessment tool in cultural diversity. Theory, method and examples. Nursing Research, 33 (4), 198-203.

Brink, P.J. (1989). Ethics across cultures. Editorial, Western Journal of Nursing Research, 11 (5), 518-519.

Brink, P.J. (1989a). The fattening room among the Annang of Nigeria. Medical Anthropology, 12, 131-143.

Brink, P.J. (1989b). The fattening room of the Annang of Nigeria. Proposal submitted to the Alberta Foundation for Nursing Research. University of Alberta, Edmonton: Alberta.

Brink, P.J. (1991). The fattening room. Canadian Nurse, 87 (9), 31-32.

Brink, P.J. (1992). Issues of reliability and validity. In J.M. Morse (Ed.) Qualitative nursing research: A contemporary dialogue. Newbury Park, CA: Sage.

Brink, P.J. & Wood, M.J. (1988). Basic steps in planning nursing research: From question to proposal. Boston, MA: Jones and Bartlett.

Burns, N. & Grove, S.K. (1987). The practice of nursing research: Conduct, critique and utilization. Philadelphia, PA: Saunders.

Callahan, D. (1987). Setting limits: Medical goals in an aging society. Toronto: Simon & Schuster Inc.

Callahan, S. (1988). The role of emotion in ethical decision- making. Hastings Center Report, June/July, 9-14.

Campbell, J. (1959). The masks of the gods: Primitive Mythology. New York: Penguin Books.

Capra, F. (1983). The turning point: Science, society and the rising culture. Toronto: Bantam.

Carper, B.A. (1986). The ethics of caring. In P.L. Chinn (Ed.). Ethical issues in nursing. Rockville, MD: Aspen Systems.

Carnoy, M. (1984). Education as cultural imperialism. New York: David McKay.

Carothers, J.C. (1948). A study of mental derangement in Africans, and an attempt to explain its peculiarities, more especially in relation to the African attitude to life. Psychiatry, 11, 47-86.

Chirot, D. (1977). Social change in the twentieth century. Toronto: Harcourt Brace Jovanovich.

Cooper, M.C. (1990). Reconceptualizing nursing ethics. Scholarly Inquiry for Nursing Practice: An International Journal, 4 (3), 209-218.

Crane, J.G. & Angrosino, M.V. (1974). Field projects in anthropology: A student handbook. Morristown, NJ: General Learning Press.

Cruickshank, J. (1989). The crushed hopes of continental giant. Toronto, ON: Toronto Globe and Mail. (October, 14th).

Davis, A.J. (1978). Ethical dilemmas in nursing practice. New York: Appleton-Century-Crofts, pp.27-29.

Davis, A.J. (1990). Ethical issues in nursing research. Western Journal of Nursing Research, 12 (1), 128-130.

deChesnay, M. (1983). Cross-cultural research: Advantages and disadvantages. International Nursing Review, 30 (1), 21-23.

Dossetor, J.B. (1992). Prenatal diagnosis: Selective, not elective terminations. The Bioethics Bulletin, 4 (2), 6-7.

Dracopoulou, S. & Doxiadis, S. (1988). Care of the Dying: In Greece, lament for the dead, denial for the dying. Hastings Center Report, 18 (4), 15-16.

Engelhardt, H.T. (1989). Contested Terrain: **Pluralism** and the good. Hastings Center Report, Sept/Oct. 33-35.

Engelhardt, H.T. (1992). The search for a universal system of ethics: Post-modern disappointments and contemporary possibilities. In C.M. Kjellstrand and J.B. Dossetor (Eds.), Ethical Problems in Dialysis and Transplantation. Draft. Dordrecht, Netherlands; KLUWER Academic Publishers.

Ekandem, M. J. (1957). Ibibio farmers and some of their customs. The Nigerian Field, 22 (4), 169175.

Essien, P.P. (1980). Proverbs as cultural tools of education in Nigeria: Annang as a base. Calabar, Nigeria: Cross River State Newspaper Corporation.

Etuk, J.D. (1987). Human rights and violations: The Nigerian experience. Proceedings of the International Conference on Human Rights, Presidential Hotel, Port Harcourt, June, 9-11.

Feldman, E. (198S). Medical ethics the Japanese way. Hastings Center Report, 15 (5), 21-24.

Field, P.A. & Morse, J.M. (1985). Nursing research: The application of qualitative approaches. Rockville, MD: Aspen Publishers Inc.

Forde, C.D. & Jones, G.I. (1950). The Ibo and Ibibio speaking people of southeastern Nigeria. London: International African Institute.

Foster, G.M. (1965). Peasant society and the image of limited good. American Anthropologist, 67, 293315.

Foster, G.M. (1987). World Health Organization behavioral science research: Problems and prospects. Social Science and Medicine, 24 (9), 709-717.

Foster, G.M. & Anderson, B.G. (1978). Medical anthropology. New York: John Wiley and Sons.

Fredrikson, B. (1983). Statistics on education in developing countries. Paris: UNESCO.

Freire, P. (1987). Pedagogy of the oppressed. New York: Continuum.

Fry, S. (1985). Individual vs aggregate good: Ethical tension in nursing practice. International Journal of Nursing Studies, 22 (4), 303-310.

Giger, J.N. and Davidhizar, R.E. (1991). Transcultural nursing: Assessment and intervention. Toronto: Mosby.

Gilligan, C. (1982). In a different voice. Cambridge, MA: Harvard University Press.

Gladwin, C.H. (1989). Ethnographic decision tree modeling. Qualitative Research Methods, 19. London: Sage.

Grant, J.P. (1987). The state of the world's children 1987. Oxfordshire, UK: Oxford University Press.

Habgood, J. (1986). Searching for our moral roots. British Medical Journal, 293, 20-27.

Hodgson, C. (1982). The social and political implications of tuberculosis among native Canadians. Canadian Review of Sociology and Anthropology, 19 (4), 502-512.

Horton, R. (no date). African traditional thought and western science. Africa, 37, 50-71.

Igbinosun, P.E. (1990). Nursing in Nigeria. Canadian Nurse, 86 (3), 28-30.

Jeffreys, M.D.W. (1950). Age-groups among the Ika and kindred people. African Studies, 9 (4), 157-166.

Jeffreys, M.D.W. (1958). The Nyama society of the Ibibio women. African Studies, 15 (1), 15-28.

Johnson, S.E. (1932). Intelligence report on Afaha Obong clan, Abak district, 1932. Typescript.

Johnstone, M.J. (1988). Law, professional ethics and the problem of conflict with personal values. International Journal of Nursing Studies, 25 (2), 147-157.

Kilner, J. F. (1981). A moral allocation of scarce lifesaving medical resources. Journal of Religious Ethics, 9, 245-285.

Kilner, J.F. (1983). Who shall be saved? An ethical analysis of major approaches to the allocation of scarce lifesaving medical resources. Doctor of Philosophy Dissertation. Harvard University.

Kilner, J.F. (1984). Who shall be saved? An African answer. Hastings Center Report, June, 18-22.

King, K. W. (1983). Origins of frustration and success in efforts to combat malnutrition in pre-school children. Journal of Tropical Pediatrics, 29, 87-92.

Kleinman, A., Eisenberg, L. & Good, B. (1978). Culture, illness and care: Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine, 88, 251-258.

Kluckhohn, F. (1951). Dominant and variant cultural value orientations. Social Welfare Forum, 97, 113-127.

Kluckhohn, F. & Strodtbeck, F. (1961). Variations in value orientations. Westport, CN: Greenwood Press.

Kofoworola, A.B.U. (1988). The Nigerian folklore: Types, functions and social import. 7th Annual Conference of the Nigerian Folklore Society December 6-8, 1988. University of Lagos.

Kulig, J. (1987). Conception and fetal development: Ideas shared by Cambodian refugee women. Final Report. Edmonton: Local Board of Health.

Kuran, G.T. (1989). Encyclopedia of the 3rd world (3rd Ed.). Vol. II. New York: Facts on File.

Laidlaw, M. (1988). Dynamic health care: The multicultural challenge. Canadian Health Care Management, 33, 33-41.

Last, J.M. (1987). Public health and human ecology. East Norwalk, CN: Appleton-Lange.

Lawless, R., Sutlive, V.H. & Zamora, M.D. (1983). Fieldwork: The human experience. New York: Gordon & Breach.

Lindbeck, V. (1984). Thailand: Buddhism meets the western model. Hastings Center Report, 10 (2), 24-26.

Maclean, U. (1971). Magical medicine: A Nigerian case study. London: Allen Lane The Penguin Press.

Maquet, J. (1972). Africanity: The cultural unity of black Africa. London: Oxford University Press.

Martin, M.E. and Henry, M. (1989). Cultural relativity and poverty. Public Health Nursing, 6(1), 28-34.

Mason, D.J. (1981). Perspectives on poverty. Image, 13, 82-85.

Mba, N.E. (1982). Nigerian women mobilized. Berkley, CA: Institute of International Studies.

McGuire, M.B. (1987). Religion: The social context. (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Meleis, A.I. & Jonsen, A.R. (1983). Medicine in perspective: Ethical crises and cultural differences. Western Journal of Medicine, 138 (6), pp.889-893.

Messenger, J.C. (1957). Anang acculturation: A study of shifting cultural focus. Ann Arbour, MI: University of Michigan.

Messenger, J.C. (1959a). The role of proverbs in Nigerian judicial system. Southwestern Journal of Anthropology, 15, 64-73.

Messenger, J.C. (1959b). Religious acculturation among the Anang-Ibibio. In W. Bascom and M. Herskovits (Eds.). Continuity and change in African cultures. (pp.279-299). Chicago, IL: The University of Chicago Press.

Messenger, J.C. (1959c). The Christian concept of forgiveness and Anang morality. Practical Anthropology, 6, 97-102.

Messenger, J.C. (1970). Reinterpretations of Christian and indigenous belief in a Nigerian nativist church. In J. Middleton (Ed.). Black Africa: It's people and their cultures today (pp.212-222). New York.

Milio, N. (1967). Values, social class and community health services. Nursing Research, 16 (1), 26-31.

Minami, H. (1985). East meets west: Some ethical considerations. International Journal of Nursing Studies, 22 (4), 311-318.

Mishler, E.G. (1979). Meaning in context: Is there any other kind? Harvard Educational Review, 49 (1), 1-19.

Morse, J.M. (1986). Quantitative and qualitative research: Issues in sampling. In P. Chinn (Ed.). Nursing research methodology: Issues in nursing (pp. 181-191). Maryland: Aspen Press.

Noah, M.E. (N.D.). African religion in old Calabar. Journal of African Studies, 103-116.

Obarisiagbon, V.A.O. (1988). Ethical approach to health care. Lagos, Nigeria: Macmillan.

Ogbeide, N.I. (1967). The relative merits of preventive and curative services in the maintenance of health and nutrition in the rural African child. Journal of the National Medical Association, 59 (4), 242-248.

Ogbeide, N.I. (1968). Socio-economic factors in diseases of infancy and childhood. Ghana Medical Journal, 7 (3), 129-138.

Oji, M.K. (1982). The Nigerian ethical revolution 1981-2000 AD. Nigeria: M.K. Oji.

Ojo. O.A. (1965). The pattern of anemia in western Nigerian. Journal of Tropical Medicine and Hygiene, 68, 32-36.

Ojo, O.A. (1974). A ten-year review of maternal mortality rates in the University College Hospital, Ibadan, Nigerian. American Journal of Obstetrics and Gynecology, 118, 217-222.

Olukoya, A.A. (1986). Traditional child spacing practices of women: Experiences from a primary care project in Lagos, Nigeria. Social Science and Medicine, 23 (3), 333-336.

Oni, G.A. (1985). Effects of women's education on postpartum practices and fertility in urban Nigerian. Studies in Family Planning, 16 (6), 321-331.

Oyebula, D.D.O. (1980). Perinatal care by traditional healers-midwives of Nigeria. International Journal of Gynecology/Obstetrics, 18, 293-296.

Oyeneye, O.Y. (1985). Mobilizing indigenous resources for primary health care in Nigeria: A note on the place of traditional medicine. Social Science and Medicine, 20 (1), 67-69.

Peel, J.D.Y. (1978). Qlaju: A Yoruba concept of development. The Journal of Development Studies, (published quarterly), 139-165.

Pelto, P.J. & Pelto, G.H. (1978). Anthropological research - The structure of inquiry. (2nd ed.). Cambridge: Cambridge University Press.

Pesznecker, B.L. (1984). The poor: A population at risk. Public Health Nursing. 1 (4), 237-249.

Phenix, P.H. (1969). The moral imperative in contemporary American education. Perspectives in Education, 2 (2), 6-13.

Rachels, J. (1980). The limits of rationality for moral guidance: Can ethics provide answers? Hastings Center Report, June, 32-40.

Ransome-Kuti, O. (1986). Child health in Nigeria: Past, present and future. Archives of Diseases in Childhood, 61, 198-204.

Reid, D. (1992). Ethics and accountability. A presentation by Dr. S. Fry at the Royal Alexandra Hospital Department of Nursing. AARN Newsletter, 48 (7), 25-26.

Rotimi, O. (1971). The gods are not to blame: A play. Ibadan, Nigeria: University Press.

Sanda, A.O. (Ed.). (1976). Ethnic relations in Nigeria: Problems and prospects. Ibadan, Nigeria: Caxton Press.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8 (3), 27-37.

Simmons, D.C. (1958). Efik riddles. Folklore, 69, 26-33.

Simmons, D.C. (1958). Specimens of Efik folklore. Folklore, 66, 417-424.

Simmons, D.C. (1960). Sexual life, marriage and childhood among the Efik. Africa, Vol. XXX, (2), 153-165.

Simmons, R.C. and Hughes, C.C. (1985). The culture-bound syndromes. Boston, MA: D. Reidel Publishing.

Smith, H.L. (1980). Ethical considerations in research involving human subjects. Social Science and Medicine, 14A, 453.

Spradley, J.P. (1979). The ethnographic review. Toronto: Holt, Rinehart and Winston.

Steele, S.M. & Harmon, V.M. (1983). Values clarification in nursing. (2nd ed.). Norwald, CN: Appleton-Century-Crofts.

Storch, J. (1982). Patient's rights: Ethical and legal issues in health care and nursing. Toronto: McGraw-Hill Ryerson.

Talbot, P.A. (1914a). Some Ibibio customs and beliefs. Journal of the African Society, Vol. XIII, LI, 241-242.

Talbot, P.A. (1914b). The land of the Ibibios, southern Nigeria. The Geographical Journal, July - December, 287-306.

Talbot, D.A. (1915a). Woman's mysteries of a primitive people: The Ibibios of southern Nigeria. London: Cassell and Company.

Talbot, D.A. (1915b). Among the Ibibios of southern Nigeria. Harper's Magazine. 600-608.

Talbot, P.A. (1923). Life in Southern Nigeria: The magic, beliefs and customs of the Ibibio tribe. London: Macmillan and Company.

Tranoy, K.E. (1988). Biomedical value conflict. Hastings Center Report, 18 (4), 8-11.

Tripp-Reimer, T. (1985). Combining qualitative and quantitative methodologies. In M. Leininger (Ed.). Qualitative research methods in nursing. (pp.179-194). Orlando, FL: Grune - Strutton.

Turnbull, C.M. (1972). The mountain people. New York: Simon & Schuster.

Uchendu, V.C. (1965). The Igbo of southeast Nigeria. Toronto: Holt, Rinehart & Winston.

Udo, U.E. (1983a). The history of the Annang people. Calabar, Nigeria: Apcon Press Ltd.

Udo, E.A. (1983b). Who are the Ibibio. Onitsha, Nigeria: Africana-Fep Publishers Ltd.

Udom, I.V. (1985). Annang concept of totem and social taboos: A religio-social analysis. Unpublished Manuscript. University of Cross River State, Nigeria.

Udomesiet, D.U. (1983). Mr. Speaker: An inside view of the Cross River State house of assembly. (19791982). Calabar, Nigeria: Government Printer.

Umoren, U.E. (1990). Religion and traditional medicine: An anthropological case study of a Nigerian treatment of mental illness. Medical Anthropology, 12, 389-400.

Veatch, R.M. (Ed). (1989). Cross cultural perspectives in medical ethics: Readings. Boston: Jones and Bartlett.

Whiting, J.W.M., Child, I.L. & Lambert, W.W. (1966). Field guide for a study of socialization. Six culture series, Vol. 1. New York: John Wiley & Sons.

Williams, T.R. (1967). Field methods in the study of culture. Toronto: Holt, Rinehart & Winston.

Wright, R.A. (1987). Human values in health care: The practice of ethics. Toronto: McGraw-Hill.

Yoder, S.P. (1982). Issues in the study of ethnomedical systems in Africa. In S.P. Yoder (Ed.). African health and healing systems: Proceedings of a symposium. Los Angeles, CA: African Studies Center.

Zartman, I.W. (1983). The political economy of Nigeria. New York: Praeger.

Appendix A

CASE STUDY 1

There is a village elder who is ill. He complains of pain at the base of his head, weakness, shaking legs, slow speech and movements and not being able to hear his heart beating. A traditional healer is called. The elder says that the night before he felt as though nails had been pounded into his chest and ropes had been tied around his chest causing great pain. He felt the spirits were very strong. The healer gives him medicine on his body and for him to drink. He puts snuff in each nostril. His family stays with him. Many days later the elder is taken to the hospital in Abak and has surgery.

CASE STUDY 2

One evening, a man, his wife and their sick young child arrive at a family members home to ask if they may have transport for taking the child to the hospital. The child lies very still in the mother's arms and does not respond to touch or noise. The child's breathing is similar to a gasp or soft cry. It appears that the evening before, he drank a bottle of kerosene and as the father was not at home, the mother mixed palm oil, eggs and coconut milk to get the child to vomit. Now that the father is home, the parents have decided that they must seek treatment at a hospital. A few hours after arrival at the hospital, despite the doctor's best efforts, the child dies.

CASE STUDY 3

A young woman and her baby are sitting on a bench outside of the local hospital. The woman has been told that her child is very ill and must receive treatment. The treatment however, is expensive and the woman does not have enough money with her. Many people walking by the hospital stop to speak to the mother and suggest that she sell her clothes in order to have her baby receive treatment. They also add that there are other people in her village who own the baby who must give her money for the treatment. The mother cries

stating that she has other small children who need her, her husband is away from home and that she cannot possibly stay with her baby at the hospital. The nurse from the hospital comes outside to examine the child once again stating that the baby will need a high protein diet for a long time to come. The nurse tells the **mother what** foods to feed the baby and highly recommends that the child first be treated in the hospital before returning home. The mother is then left alone to make her decision. She remains on the bench softly crying.

CASE STUDY 4

There are two men living in a village who are very different from each other. Emem is very well respected, has two wives and many children, and has done good things for other people living in the village. Ifiok has never married or had children, has been happy to work on his small garden plot and has had very little to do with village projects. One day at a village celebration, both men become very ill. The two men are taken to the native healer and told they are very sick and could die. The native healer also states that he has only enough medicine to help one man and that he will need to know who should receive the medicine. The village elders are told of the problem and asked to help decide which of the two men should get the medicine.

CASE STUDY 5

There is an elderly woman living in the village who has swelling on her right side and is vomiting on a regular basis. The woman is only able to walk bent over, states that she is in great pain and yet refuses to be taken to the hospital. Other members of the family have obtained medicine from the native healer which does not appear to have made her any better. The eldest son who is out of town, has not yet been to see his mother. When family members ask if the mother will agree to be taken to the hospital, she replies that she will go to the "devil house" if her family wants. The family however is concerned about the cost of treatment and decide that first they will find out

what is wrong, how much it will cost to fix and then have a family meeting to decide on what they will do.

The mother, a younger son and a grand-daughter all travel to the hospital. There is an agreement that treatment will not be started before the family discusses the matter, however, the grand-daughter is available to stay at the hospital if the grand-mother must be admitted by the doctor. The doctor recommends surgery at N42 and suggests that the woman will become more and more ill and perhaps die without treatment. It is also suggested that because the woman is so ill that she first be admitted to hospital to be strengthened before surgery, which will cost an additional N20. As the cost is very high, the entire family returns to the village to discuss their course of action. Other family members are asked to help with the cost of surgery, but no money is made available. Following a family discussion, it is decided that the surgery and treatments are too expensive for an old woman and that they will be unable to have their mother treated. The mother becomes very ill and dies a few weeks later.

POSSIBLE QUESTIONS:

What is happening here?
Who makes the decision about what will be done?
How does the cost affect the decision?
What would you have done? Why?
What would your decision have been for a:
- man?
- woman?
- male child?
- female child?
- unmarried man?
- unmarried woman?

Would a man make this decision alone?
Would a woman make this decision alone?
What would your decision be for a man without children?
What would your decision be for a woman without children?
What would happen to your decision if you knew another member of the family was ill and needed money also?
Would your decision be based on a person's status?

Appendix B

Health Care Decision Making Model For The Annang Of Nigeria

I The decision that the person is ill.

A. Impairment of normal functioning.
   1. Subjective statements of ill person.
   2. Observed degree of impairment.

B. Previous experience with symptoms.
   1. Eyewitness experiences.
   2. Hearsay experiences.

II The decision that the person requires assistance.

A. Person does not require professional assistance.

B. Person requires outside professional assistance.
   1. Crises nature of illness,
   2. Degree of impairment of normal functioning.
   3. Status of individual in family.
   4. Assessment of family resources.

III The decision of which health system is most appropriate.

A. Availability of health care system.
   1. Proximity of health system.
      a. distance
      b. transportation
      c. home versus facility visit
   2. Health system can be reached.

B. Past experience with healer.
   1. Eyewitness experience with healer.
      a. trust in diagnostic capabilities

b. trust in healing capabilities
c. trust in reasonableness of fees
d. healer has accepted similar patients

2. Hearsay accounts of the above.

IV Decision to remain with the health system.

A. Agree with diagnosis and treatment plan.
1. Status of patient in the family.
2. Reasonableness of fees.

B. Improvement in patient's condition.

C. Health system agrees to treat patient with conditions.

V The decision that the patient is well.

A. All treatment conditions have been met.

B. Observable improvements in patient's condition.

C. Patient able to return to normal functioning.

Source: Brink, P.J. (1976). Decision making of the health care consumer: A Nigerian example. Paper presented at the 9th Annual Communicating Nursing Research Conference. Sponsored by the Western Society for Research in Nursing, May 5 - 7, 1976, Seattle, WA.

Appendix C

Budget for Study

1. **Personnel**

Principal investigator 16 hrs/day x 8 weeks and 8 hrs/day x 16 weeks + 12% benefits.	N/A
Research assistant (fluent in English and Annang). 12 hrs/day x 54 days @ $8.00/day.	$5,184.00
Secretarial services. 30 hrs @ $12.00/ hr. + 12% benefits.	$ 403.20
Statistical consultant. 10 hrs @ $60.00/ hr. + 12 % benefits.	$ 607.20

2. **Supplies/Services/Travel/Other**

Travel:	
Travel to and from Nigeria by air.	$ 2,500.00
Travel within Nigeria x 8 weeks.	$ 1,000.00
per diem in Nigeria @ $20/day x 8 weeks.	$ 1,120.00
Overweight luggage costs (44-300 kgs @ $9.87/kg).	$ 197.00
Immunizations for travel to Nigeria (Yellow fever, Hep B, Cholera, Hep A, Typhoid, Malaria) and a tropical first aid kit.	$ 150.00
Supplies and Services:	
Computer Coding and Analysis.	$ 200.00

Photocopying: -Data collection tools. 500 pages @ $.03/pg. -Ten copies of final report. 1000 pages @ $.03/pg. Fifty copies of final summary for participants 150 pages @ S.03/pg. Miscellaneous. 300 pages @ $.03/pg.	$ 400.00
Lit. Searches (Medline, Soc, Psych Abs)	$ 150.00
Telephone and Postage Supplies.	$ 100.00
Paper and Sundries, photo-developing	$ 200.00
Supplies (100 Audio Cassettes @ 2.99 each)	$ 299.00
Gifts for interviews conducted in Nigeria.	$ 150.00
1 Avco Portable Tape Recorder #RC12B784	$ 100.00
Typewriter reconditioning for field study.	$ 50.00
Batteries for cassette recorder.	$ 10.00
Total	**$12,920.40**

Appendix D

Description of Study and Informed Consent

Greetings; my name is Cori Paul and I am a nursing student studying at the Faculty of Nursing, University of Alberta, Edmonton, Canada. I have come to Afaha Obong with Prof. Brink, my teacher at the university, to ask what you do when someone is sick. Very little is known about these things, and I believe that people who work in clinics and hospitals both in Nigeria and in Canada, where I come from, could benefit from knowing more about the way you make health care decisions.

[For village elders] I would like to ask permission to speak with both men and/or women of your village about what they do when someone gets sick. If you agree to let me speak with your people, I will speak with those you say I should speak with. I will not speak with people you do not want me to speak with. If you do not want me to talk to anyone in your village, I will go to another area and talk with people there.

[For study Participants] I would like to ask to speak with you about what you do for people who are sick. If you feel that you do not want to speak with me that is fine, I will find someone in another area to speak with. If you do agree to speak with me, but later decide that you want to stop, I will understand. We will stop when you decide. If while we are talking, I ask a question that you do not like, please tell me and I will try not to ask the question again. If you want to speak with me, but do not want others to know, I will not tell anyone we have spoken, I will not put your name on the paper(s), and I will not include your name when I write about our talk(s). If you would feel better if I did not take any pictures, I will not take any pictures. If you want me to take pictures but do not want people to know your name, I will not put your name with the pictures. If you do not want me to use the name of the village you live in, I think it will be better not to have any talks. There is very little knowledge about how the Annang from Afaha Obong

make health care decisions and so I hope the talks we have, and the notes and pictures I take, will help me to write about the way in which these decisions are reached. If it is alright with you, I would like to make a tape-recording of our talk(s) and also write some notes. Later, I would like to take pictures of your home, the compound and your family and then give you a copy of the best picture(s). I promise to keep all the notes, pictures and tapes from our talk(s) together at my home until after I write my paper. Then I will give all of the information to Prof. Brink who has promised to keep it and share it with those people who are interested in the Annang. Prof. Brink agrees to keep the information in her office at home so that if someone wants to know more about how the Annang make health care decisions, they will be able to see this information after talking with Dr. Brink. When Prof. Brink dies, she says she "will give all these things to the Annang university library so that other people who want to study the Annang will have a record."

Our talks can be short or long, and will end when you say so. Some of our talks may include other members of your compound and/or village. When this happens, I hope you will discuss your answers to the questions with the other people present. There will be someone here who speaks both Annang and English so that everyone will know what is being said during the talks. I will ask you questions about your education, marriage, work and religion, because these things will be another way of helping me to understand the answers you give me. Sometimes I will tell you a story about a person who is sick and then ask how you would help that person and how you made your decision. These talks will be the long ones. We can also talk about other times you have been with sick people and how you made decisions about what to do for them. The talk(s) can take as long as you wish. After we have spoken, I will go home and write more notes and try to understand all that you have told me. Once I have written my notes, I will want to speak with you again to make sure I have not made any mistakes. I will also come back to speak with you if I find I do not understand what you have said. If you have any questions about Prof.

Brink, myself, the study, and/or what the information will be used for, I will be pleased to speak with you. I will also send the paper I write to the village elders, so that you will be able to show it to those people you think may be interested. The best way to reach me (depending on the village and the contact person for that village) is to contact Mrs. R. Udomesiet, Mr. E. Sade, Mr. C. Ebong, or Prof. Brink. If you agree to speak with me about how health care decisions are made, please place your name here, and I will leave a copy of this paper with you:

Name:

Village:

Researcher:

Interpreter:

Date:

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Appendix E

DEMOGRAPHIC QUESTIONNAIRE

Personal Information

Name:
Age:
What is your father's village:
What is your mother's village:
Sex:
Are you married now:
Yes No
If yes: How many wives do you have:
How long have you been married (to each):
Were you ever married to someone else:
Yes No
If yes: To how many others:
How long did these marriage(s) last:
First marriage:
Second marriage:
How many children have you had
(including those that have died):
How many of these children are still living:
Have you ever had other people's children live
with you in your compound?
If yes: Who were these children:
How many children were there:

Educational Background

How many years of schooling have you had:
What is the highest level you reached in school:
What kind of school did you attend:
Did (each) husband/wife attend school:
How many years of schooling did they have:
What is the highest level in school they reached:
How many of your children attend school:
What is the highest level of schooling your children
have
reached:

Religion

What is your religion:
How much does your god affect the way you live your
life:
Very much: Somewhat: Very little:

Employment

Current occupation:
What jobs have you held in the past:
Where were each of these jobs located:
Occupation of (each) husband/wife:
What jobs has (each) husband/wife held in the past:
Where were each of these jobs located:

Health Care Service Utilization

What health care services do you use most often for
your family:
Medical Doctors:
Nurses:
Traditional Birth Attendants:
Native Healers:
Primary Health Care Centers:
Hospitals:
Other:
How do you decide on health care services you will use: On my own:
With the help of village elders:
With friends:
With family:
With a western health care worker:
With a native health care worker:
Other:

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APPENDIX F

May 29, 1989

To Whom it may concern:

I agree to the conditions as set forth by Ms. Coral Paul in her thesis proposal, "Cultural Pluralism and Ethical Decision Making."

1. All information collected by Ms. Paul will be added to my archival materials on the Annang.

2. I agree that I will donate all raw data collected during Ms. Paul's eight week field research among the Annang of Nigeria to the Annang University at Akwa Ibom State, Nigeria, upon my death.

3. Future access to the information by myself, Ms. Paul, and/or other Annang scholars will be monitored for their ethical use according to the appropriate mandates of the institution and the time.

4. Ms. Paul retains the right to destroy her raw data if utilization of the information by myself or others is believed (by Ms. Paul) to be detrimental to the Annang.

Sincerely,

Pamela J. Brink, RN, PhD, FAAN
Professor and Associate Dean, Research

University of Alberta
Edmonton

Faculty of Nursing

Canada T6G 2G3 3-120 Clinical Sciences Building

APPENDIX G

Certification of Ethical Acceptability for Research Involving Human Subjects

NAME OF APPLICANT: Coral Paul

TITLE OF PROJECT: Cultural Pluralism and Ethical Decision-Making

The members of the review committee, having examined the application for the above-named project, consider the procedures, as outlined by the applicant, to be acceptable on ethical grounds for research involving human subjects.

June 16, 1989
Date

Margaret J. Harrison
M. Harrison, RN, PhD
Acting Chair
Ethics Review Committee
Faculty of Nursing

Appendix H

Annang Proverbs

The following is a list of proverbs used by informants during the interview process and documented during participant observation. In certain cases, the Annang proverb itself appears.

1. The cleaner of the sick room's mess has less gratitude than the donor of a small amount of money to pay the bills.

2. **Ada ke urun?**
   Are you so small?

3. **Eto idaha ikpon ikaba akai.**
   A tree cannot stand alone and form a forest.

4. He that has a brother must hold him to his heart. For a kinsman cannot be bought in the market. Neither is a brother bought with money. He who has brothers has more than riches can buy.

5. **Annang ise imana iba.**
   Cow's cannot give birth to twin calves.

6. Consider your elders sent by God - to raise your awareness of your environment.

7. **Mbobo ekpekam uma nseide idem akan?**
   If **mbobo** loves you, why do you fear the oil?

8. **Iton ama odu uwem akon-nkua.**
   When there is life there is hope.

9. **Idehe-usen ekpu atibeke ekpat abia-ibok ke mfuk ase afut.**
   It is not a day that the rat sought the bag of charms that it's mouth will swell.

10. When you have a yam, when it is time, it mustn't grow very well. The remains will grow just upper - not inner and that is how women are now.

11. There is no limit to what a person may ask of you. Your limits are on what you will choose to act upon.

12. The man who knows he will die in two weeks will make sure that he and his family are well taken care of in all ways.

13. The body cannot lie on the floor and rot - there must be someone to bury the body.

14. **Akpan isinaka ufok eka ke idem iden.**
The first son doesn't sleep in the mother's house in good condition.

15. The milk tooth is the tooth that breaks ground and eases the way for the permanent teeth, which carry on the functions of the milk tooth.

16. The person who gets out from the house will always complain of what the person or owner has done to him. Whether good or bad. That he will never like to tell the people what he has done to the owner of the house whether good or bad.

17. **Etok unem oturu - uton ese okop item ke esio efere.**
A small hen who doesn't hear, always hears when it hits the pot.

18. A child who steals eggs or meat does not change from this habit.

19. You were given two ears to hear, so that you can always ensure that you always hear both sides of a story.